MISSOURI HOUSE OF REPRESENTATIVES

REPORT OF THE INTERIM COMMITTEE ON MEDICAID COST AND CONTAINMENT

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January 27, 2004

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The Honorable Catherine Hanaway
Speaker of the House
State Capitol, Room 308
Jefferson City, Missouri 65101

Dear Madam Speaker:

Your Interim Committee on Medicaid Cost and Containment, acting pursuant to your request, has met, taken testimony, deliberated, and concluded its study on cost containment measures for the Medicaid program. The undersigned members of the Committee are pleased to submit the attached report.

Representative Jodi Stefanick
Chair

Representative Marsha Campbell

Representative Wayne Cooper

Representative Melba Curls

Representative Barbara Fraser

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Representative Kate Meiners

Representative Sam Page

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EXECUTIVE SUMMARY

General Comments

Medicaid was created by Congress, through Title XIX of the Social Security Act in 1965. It was established to provide medical assistance for individuals and families with low incomes and limited resources. From its inception federal and state governments have jointly funded the Medicaid program. All 50 states participate in the Medicaid program, and in exchange for receiving federal matching funds, the federal government requires states to provide services to several mandatory groups of residents. States must also provide several mandatory services to all recipients in order to be eligible for matching federal funds.

Eligibility

Federal Medicaid statutes require coverage of certain mandatory eligibility groups, but give states some flexibility in determining eligibility, and in electing to cover optional eligibility groups. All individuals who qualify for Medicaid must meet both categorical guidelines and financial guidelines. The Family Support Division of the Missouri Department of Social Services is responsible for determining eligibility for Medicaid. In 2001, Medicaid eligibles made up 18.3% of Missouri's population, while they made up 16.576% of the nation's population. As of November 30, 2003, 978,495 Missourians received Medicaid benefits.

The Interim Committee learned that Missouri currently imposes asset limits on recipients of Medicaid for the elderly, blind, and disabled, but does not currently impose asset limits on recipients of Medical Assistance for Families or MC+ for Pregnant Women.

Managed Care

The Medicaid managed care program in Missouri is referred to as the MC+ Managed Care program. MC+ Managed Care started in Missouri in 1995. Currently only 37 counties, all of which fall along the I-70 corridor are participating in MC+ Managed Care. As a condition of receiving benefits in the Medicaid program, children, pregnant women, TANF recipients, and children and youth in the custody of the state are mandated to enroll in MC+ Managed care if they reside in the managed care areas. It is estimated that Missouri has realized $200 million in savings under the MC+ Managed Care program during 2002 alone.

Long Term Care

Medicaid comprises a significant share of long-term care services in Missouri. It is projected that Missouri's Medicaid program will spend over one billion dollars in 2003 on nursing home care. The Interim Committee learned that nationally, there is a shifting of costs from nursing home care to home and community based care. From 1992 to 1998 the percentage of Medicaid spending on home and community based care as a percentage of total Medicaid long-term care spending has increased from $44 billion or 15% to $59 billion or 25%.

Pharmaceuticals

Prescription drugs are an optional service under Federal law, but as of January 2003, every state in the nation participates in prescription drug coverage as part of their state Medicaid program. According to the Urban Institute, Medicaid payments for outpatient pharmaceuticals rose over 16% annually between 1990 and 2000. State Medicaid officials in 38 states identified prescription drugs as one of the most significant factors contributing to Medicaid expenditure growth in fiscal year 2003. Like many of its sister states, Missouri has experienced significant growth in its Medicaid pharmaceutical program in recent years. Missouri has also recently implemented several measures designed to help contain the rising costs associated with the pharmacy program.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are private not-for-profit or public entities that provide comprehensive primary health care, maternity and pre-natal care, preventative care for infants, children, and adults, some emergency care, and pharmaceutical services for recipients of all ages. FQHCs provide community-based and consumer driven services. Federal law requires at least 51% of an FQHC's board of directors to be comprised of individuals who are patients at the center. They are located in rural or urban communities that experience barriers to receiving health care, and must provide care to all residents of their service area. According to the Missouri Primary Care Association, Missouri FQHCs served 77,000 Medicaid patients last year, at an estimated $663 savings per Medicaid patient.

Third Party Recovery

Federal law requires Medicaid to be the payer of last resort. When available, Medicaid expenditures must be offset by third party resources. In fiscal year 2002, Missouri's Third Party Liability unit collected a total of $31 million and in fiscal year 2003, they collected a total of $28 million. In addition to the staff of the Third Party Recovery unit in the Division of Medical Services, the Division contracts with Health Management Systems, Inc for third party fund recovery. Health Management Systems identifies and recovers funds from third parties who were responsible for coverage that was actually paid by the state Medicaid program. Health Management Systems is the nation's largest provider of third party recovery services, and has recovered over $2 billion for 30 states. Since 1998, Health Management Systems has recovered over $66 million for Missouri's Medicaid program. Health Management Systems has recently been awarded a third party recovery contract to provide additional services for the Department of Social Services, as well as services for the Department of Mental Health.

House Interim Committee on Medicaid Cost and Containment

INTRODUCTION

The House Interim Committee on Medicaid Cost and Containment was formed at the authorization of House Speaker Catherine Hanaway. The committee was charged with evaluating the growth in costs associated with Missouri's Medicaid program, the growth in eligibility, the costs associated with optional programs, and comparing Missouri's Medicaid program to those of other states. The members of the committee included Representatives Jodi Stefanick (Chair); Marsha Campbell; Wayne Cooper; Melba Curls; Barbara Fraser; Gayle Kingery; Kate Meiners; Sam Page; Charles Portwood; Mike Sager; Robert Schaaf; Bryan Stevenson; Mike Sutherland; and Kevin Threlkeld.

The Committee held an organizational meeting on September 9, 2003 in Jefferson City, Missouri. The Committee then met three more times; October 10, 2003 in Jefferson City, Missouri; October 27, 2003 in St. Louis, Missouri; and November 17, 2003 in Columbia Missouri. Each of the committee's meetings focused on particular areas of the Medicaid program. These areas included eligibility, managed care, pharmaceuticals, long-term care, disease management, services for the disabled, and nursing home reimbursement. Witnesses included officials from the Missouri Department of Social Services, and the Missouri Department of Health and Senior Services, as well as representatives of managed care organizations, nursing homes, and pharmaceutical companies. A complete list of witnesses appears in Appendix A.

GENERAL COMMENTS

Medicaid Background

Medicaid was created by Congress, through Title XIX of the Social Security Act in 1965. It was established to provide medical assistance for individuals and families with low incomes and limited resources. From its inception federal and state governments have jointly funded the Medicaid program. The formula for determining the federal medical assistance percentage (FMAP) that a state receives is outlined in federal law and is based on state and national per capita income. For fiscal year 2001, the average national FMAP was 60.8%[1] In Missouri, for the state fiscal year 2004, the federal government provided 61.5% of the funds and the state of Missouri provided the remaining 38.5%.

Although participation is optional, all 50 states take part in the Medicaid program. In exchange for receiving federal matching funds, the federal government requires states to provide certain services to several mandatory groups of recipients. The mandatory eligibility groups include:

- Individuals who meet the requirements of the Aid to Families with Dependent Children (AFDC) group that were in effect in their state as of July 16, 1996;
- Children under the age of six whose family income is at or below 133% of the federal poverty level;
- Pregnant women whose family income is at or below 133% of the federal poverty level. Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and post-partum care;
- All children born after September 30, 1983 who are under age 19 and whose family income is at or below 100% of the federal poverty level;
- Supplemental Security Income (SSI) recipients in most states. Some states use more restrictive Medicaid eligibility requirements that pre-date SSI;
- Recipients of federal foster care and adoption assistance under Title IV-E of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time); and
- Certain low–income Medicare beneficiaries. All Medicare beneficiaries whose incomes are below the federal poverty level receive Medicaid assistance to pay for Medicare premiums, deductibles, and cost sharing. These individuals are known as Qualified Medicare Beneficiaries or QMBs. Medicare beneficiaries whose incomes are slightly above the federal poverty level receive Medicaid assistance for the payment of Medicare premiums and are known as Specified Low-Income Medicare Beneficiaries or SLMBs[2].

Some services must be provided as part of a state's Medicaid program in order to be eligible for matching federal funds. The following services are considered mandatory:

- Inpatient hospital services;
- Outpatient hospital services;
- Services at rural health clinics and Federally Qualified Health Centers (FQHCs);
- Physician services;

- Laboratory and X-ray services;
- Pediatric and family nurse practitioners' services;
- Nursing facility services and home health services for individuals aged 21 and over;
- Home health care for individuals eligible for nursing facility services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21;
- Family planning services and supplies;
- Medical and surgical services of a dentist; and
- Nurse-Midwife services[3]

Although Medicaid is perceived as a federally mandated program for the poor, two-thirds of national Medicaid spending is now devoted to beneficiaries and services that the states voluntarily cover.[4] The largest optional component of Medicaid expenditures in Missouri is pharmaceutical expenditures. For fiscal year 2004, $937,750,000 was appropriated for the Medicaid pharmacy program.

These optional choices, rather than exogenous factors that affect all states, are the leading causes of Medicaid expenditure increases. This is supported by the fact that even during times of declining poverty, Medicaid expenditures escalated due to a number of factors. Spending and enrollment for Medicaid programs increased in the 1990s partly due to states expanding their Medicaid programs. Federal initiatives, such as the enactment of the State Children's Health Insurance Program, have also increased the number of individuals receiving Medicaid benefits. Lastly, the desire to reduce the number of uninsured individuals contributed to the expansion of Medicaid enrollment.

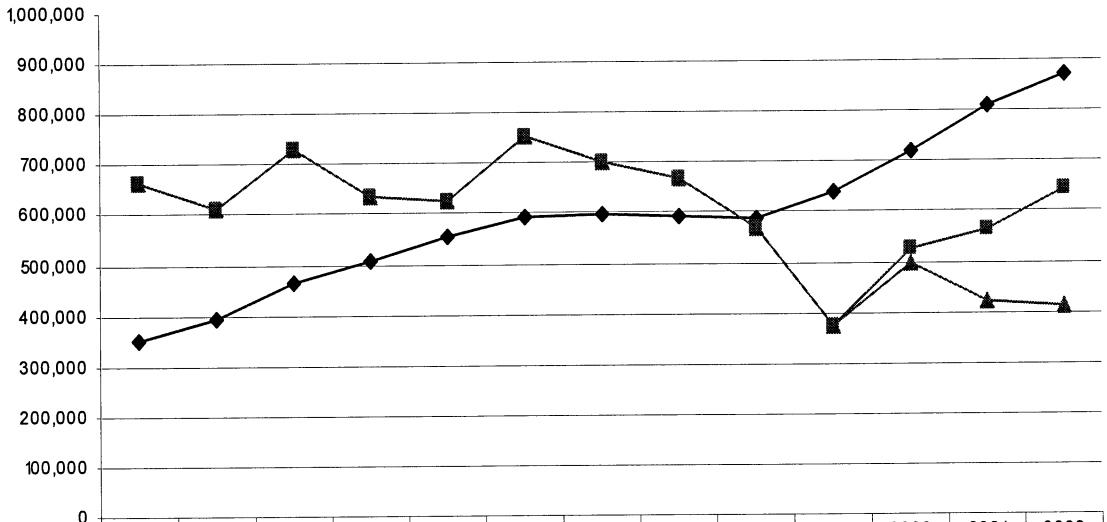
Missouri Medicaid Recent Enrollment History
Change in Enrollment from previous year[5]

	FY 99	FY00	FY01	FY02	FY03
Missouri	6.3%	16 %	11.9%	7.7%	6.6%
National	2.1%	3.7%	8.3%	9.2%	*

*Not Available

Source: Missouri Department of Social Services; Kaiser Commission on Medicaid and the Uninsured

Missouri Medicaid Enrollment Versus Number of Uninsured Fiscal Years 1990-2002[6]



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Enrollees	351,244	394,604	462,090	509,270	555,097	591,650	595,710	591,081	585,476	637,799	722,200	808,377	870,828
Uninsured (Census)*	665,000	611,000	728,000	633,000	627,000	755,000	700,000	669,000	570,000	374,000	524,000	565,000	646,000
Uninsured (Lewin)**	665,000	611,000	728,000	633,000	627,000	755,000	700,000	669,000	570,000	374,000	497,260	424,005	410,604

Sources: Missouri Department of Social Services Annual Table 5 for FY 1990-FY 2002, the U.S. Census Bureau, and The Lewin Group.

*Uninsured numbers for each year were obtained from the U.S. Census Bureau.

** Uninsured numbers for 1990 through 1999 were obtained from the U.S. Census Bureau. Uninsured numbers for 2000-2002 are Lewin Group estimates using the Missouri subsample of the Current Population Surveys (1999-2002) and corrected for Medicaid/SCHIP underreporting.

Time Line

1959 – Missouri has a limited medical assistance program covering a portion of inpatient hospital care.

1963 – Missouri added limited prescription drug and dental program coverage.

1967 – Under the provision of the Social Security Act, Missouri established the Missouri Medicaid Program. Coverage included physician's services, outpatient hospital care, and nursing home care. Eligibility was expanded to include the permanently and totally disabled and blind populations as well as expanding services to Aid to Families with Dependent Children.

1991 – The Voluntary Contribution program was implemented in Missouri. This program by federal law allowed hospitals to donate funds to the state. These funds could then be used to pull down a federal monetary match. Also in 1991, coverage of pharmaceuticals was expanded in response to federal legislation. That legislation, known as the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) required the products of pharmaceutical manufacturers who have entered into a rebate agreement with the Department of Health and Human Services to be covered by state Medicaid plans, with certain exceptions. Prior to the enactment of OBRA-90, a restricted formulary dictated the drugs that state Medicaid programs were required to cover in order to receive the federal matching funds. OBRA-90 gave states the authority to exclude some drugs from coverage, and also required states to implement prospective and retrospective drug review programs. (44)

1992 – Public Law 102-234 was enacted by the federal government that phased out the Voluntary Contribution program. Missouri passed HB1744 that year enacting the Federal Reimbursement Allowance (FRA). Implementation of the FRA program dropped the state's general revenue portion of Medicaid funding to 17% from 40%, increasing the amount the federal government pays toward the costs of the Medicaid program. (Missouri Dept of Social Services, Division of Medical Services).

1997 – The Balanced Budget Act of 1997 established Title XXI of the Social Security Act. This created the State Children's Health Insurance Program (SCHIP). The goal of this program was to help states expand Medicaid coverage to uninsured, low-income children.

Costs and Funding

In recent years, Medicaid expenditures have increased dramatically. These rapidly growing Medicaid expenditures have been attributed to factors ostensibly beyond the control of state governments, such as exploding health care costs, federal mandates, and rising levels of poverty due to a declining economy.

Historical Funding Data – Medical Assistance Budgets for State Fiscal Years 1968, 1970, 1980, 1990, 2000, and 2004:

Missouri Medicaid Funding History [7]

Year	General Revenue	Federal Funds	Other	Total Medicaid	Total Missouri Budget
1968*	12,875,000	25,778,458	261,000	38,914,458	1,142,978,696
1970*	28,053,994	32,790,576	594,000	61,438,662	1,405,510,632
1980	131,519,032	188,986,266	0	320,505,298	3,908,279,796
1990	328,514,359	483,812,719	20,230,000	832,557,078	7,751,178,663
2000	685,217,925	2,304,483,871	347,768,479	3,337,470,275	16,527,712,187
2004	849,745,877	2,978,638,532	596,014,437	4,424,398,846	19,044,667,416

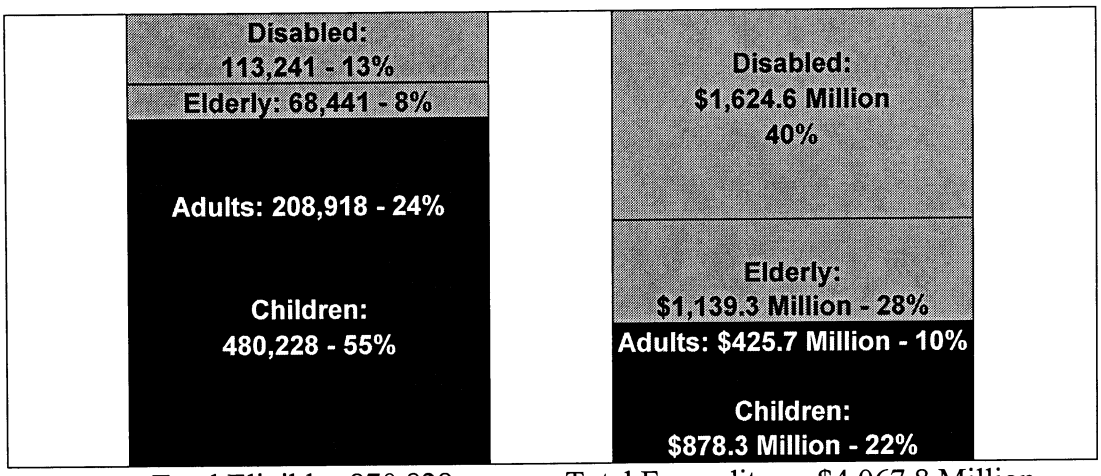
** Until 1972 Missouri's budget was appropriated on a two-year cycle.*
SOURCE: Department of Social Services, Division of Budget and Finance; The Missouri State Budget, Fiscal Years 1969-1970, 1970-1971, 1981; Missouri House of Representatives Summaries of Truly Agreed to and Finally Passed Bills, 1989, 1999, 2003. This chart is a summary of appropriated amounts and does not necessarily reflect actual expenditures.

In a national study, the Henry J. Kaiser Family Foundation measured average annual growth in state Medicaid spending between fiscal years 1991 and 2001. In that study Missouri had the highest growth rate in Medicaid spending at 16%. Following Missouri on the list was Oregon with a slightly lower growth rate rounded to 16% then Arizona with 15%. The national average in this study was recorded at 11%.[8] This is a partial list from that study:

Kaiser Foundation Study - Average Annual Growth in Medicaid Spending	
	Growth FY91-01
United States	11%
Missouri	16%
Oregon	16%
Arizona	15%
Tennessee	13%
Kansas	12%
Kentucky	12%
Illinois	11%
Arkansas	10%
Indiana	10%
Iowa	9%

Medicaid programs can be broken down into four general categories based on the type of person served: disabled, elderly, adults, and children. The chart below illustrates the relationship between each category's eligible population and expenditures. The numbers are a snapshot from fiscal year 2002, but the relationships today are similar. The chart illustrates that even though the disabled and elderly categories represent 21% of the Medicaid population, they consume almost 70% of Medicaid budget dollars.

Missouri Medicaid Enrollees and Dollars Spent by General Eligibility Category, Fiscal Year 2002



Total Eligibles 870,828 Total Expenditures $4,067.8 Million

Source, Missouri Division of Medical Services

Provider taxes are an important part of Medicaid funding in Missouri. A representative of the Missouri Hospital Association testified that over the last ten years, Missouri has used provider taxes on Hospitals, Nursing Homes, and most recently, Pharmacies, to help fund the state Medicaid program. In response to changes in federal law dealing with the voluntary contribution program and provider taxes, Missouri enacted the Federal Reimbursement Allowance (FRA) in 1992.[9]

Federal law allows states to implement these provider taxes. Generally, states that choose to implement provider taxes require specified classes of providers to pay a tax to the state. The state uses the funds to earn federal matching dollars, which are used to fund Medicaid payments. Federal law requires all taxes imposed to be uniform and broad-based, so that they are paid by all providers in a particular class at the same rate. Currently, the hospital tax is based on all net patient revenue and other revenue, excluding governmental appropriations, donations, and income from investments. The FRA assessment is substituted for general revenue dollars. The success of the FRA program has resulted in FRA becoming the state's third largest source of general revenue behind the individual income tax and sales and use taxes. According to the Missouri Hospital Association, in fiscal year 2003 the FRA generated $559,250,517 million dollars and decreased the contribution level of general revenue to the Medicaid program from 39.5% in fiscal year 1990 to 16.9% in fiscal year 2003.[10]

Missouri's Uninsured

As of 2002, about 543,300 Missourians, or 11% of the state's total population, did not have health insurance. In 2001, approximately 16% of individuals were uninsured nationally[11]. Eighty-three percent of uninsured Missourians had at least one person in the family working either full-time or part-time. About half of Missouri's uninsured had one family member working full-time, all year.[12]

According to the Kaiser Commission on Medicaid and the Uninsured, service and labor jobs are less likely to provide workers with health insurance. About 63% of uninsured workers hold service and labor jobs, although these jobs only make up about 40% of the workforce.[13] On the national level, 85% of those who become unemployed lose health insurance. The recent unemployment rate increased in Missouri from an average of 3.3% in 2000 to 5.4% in 2003, increasing the number of uninsured. The COBRA insurance benefit has become increasingly costly and recently only one in fourteen of the unemployed were eligible for and used COBRA insurance.[14]

ELIGIBILITY

Federal Medicaid statutes require coverage of certain mandatory eligibility groups, but give states some flexibility in determining eligibility, and in electing to cover optional eligibility groups. As a result, there is no single national standard for determining Medicaid eligibility.

Regardless of the individual differences between the states, all individuals who qualify for Medicaid must meet both categorical guidelines and financial guidelines. The Medicaid program in Missouri uses financial guidelines from the federal government as a basis for determining financial eligibility. Two of those guidelines are the Supplemental Security Income (SSI) guidelines, and the Federal Poverty Level (FPL). The SSI guidelines are set each year by the Social Security Administration. For 2004, the SSI income limit is $564 per month for an individual and $846 per month for a couple.[15] The SSI resource limits are $2,000 for an individual and $3,000 for a couple.

Many states simply use the SSI guidelines for determining financial eligibility for elderly, blind, and disabled individuals. Missouri however, is one of eleven "209 (b)" states. 209(b) was an option in early federal Medicaid legislation that allowed states to use 1972 financial and non-financial standards in determining eligibility instead of the federal SSI standards. If a state uses the more restrictive 1972 standards, it must allow individuals to "spend down" to the eligibility level by incurring costs for medical expenses and deducting these expenses from the individual's income. Missouri elected to use the SSI limit for an individual's income in determining eligibility, but the lower 209(b) resource limit. In Missouri, and individual can have $999.99 in assets, and a couple can have no more than $2,000 in assets.[16]

The Federal Poverty Level is based on guidelines that are updated annually by the Department of Health and Human Services and published in the Federal Register. The Federal Poverty Level for one person in 2003 was $8,980 per year, or $748.30 per month. Various percentages of the Federal Poverty Level are required for use in determining financial eligibility for Medicaid programs involving children and pregnant women. Missouri Medicaid also currently uses a percentage of the Federal Poverty Level to determine eligibility for families, elderly, blind, and disabled.

The Family Support Division of the Department of Social Services is responsible for determining eligibility for Medicaid in Missouri. Applicants fill out application forms which request information including the applicant's income, resources, household information, age of the applicant and household members, and access to health insurance. The caseworker also conducts an interview with the application to discuss the information contained in the application. The Division usually takes an applicant's word for information that is included in the application, including statements that children are living with the applicant, statements about income and resources, and statements about whether an employer offers health care coverage.

A report from the Centers for Medicare and Medicaid Services indicates that in 2001, Medicaid eligibles made up 18.3% of Missouri's population, while they made up 16.57% of the nation's population. As of November 30, 2003, 978,495 Missourians received Medicaid.[17]

In addition to the mandatory eligibility groups and services described earlier in this report, Missouri also provides coverage to several optional coverage groups, as well as coverage for several optional services. Attempts have been made in recent years to limit or eliminate funding for some of these groups. Some of these attempts have been successful, but others have been overturned by the courts.

The optional coverage groups in Missouri include the following[18]:

- Pregnant women and children up to age 1 from 133 – 185% of the federal poverty level
- Children ages 0 – 1 with family incomes above 133% of the federal poverty level; children ages 1-5 with family incomes of 133 – 300 % of the federal poverty level; and children ages 6 through 19 with family incomes of 100% to 300% of the federal poverty level.
- A second year of coverage for parents transitioning from welfare to work with incomes below 100% of the federal poverty level. This income level was lowered from 300% of the federal poverty level, effective July 1, 2002.
- Custodial parents with incomes that do not exceed 77% of federal poverty level, but that are above the July 16 1996 AFDC income limit. This income level was lowered from 100% of the federal poverty level in 2002. The change was challenged in court but ultimately upheld.

Missouri's Medicaid program also provides coverage for several optional services, including the following[19]:

- Adult dental and optical care - The legislature did not appropriate funding for these services in 2002 and 2003. As a result, the Department of Social Services took action to eliminate the provision of these services. This action was challenged in court, and in 2003, the court ruled that these services could not be eliminated unless there was a change in state law;
- Prescription drugs;
- Rehabilitation and physical therapy services;
- Nursing facilities for children;
- In-home services;
- Home health services for individuals under the age of 21;
- Podiatry services;
- Clinic services;
- Mental Health services; and
- Services in an Intermediate Care Facility for the mentally retarded for individuals over 21 years of age.

Missouri Medicaid Spending on Mandatory and Optional Eligibles and Services, Fiscal Year 2002

	Mandatory Eligibles	Optional Eligibles	***Total Spending on Mandatory and Optional Services***
Mandatory Services	$2,266,562,731	$216,856,830	$2,483,419,561
Optional Services	$1,515,160,114	$69,253,780	$1,584,413,849
Total spending on Mandatory and Optional Eligibles	$3,781,722,845	$286,110,610	

NOTE: These figures are from fiscal year 2002, and they represent total Medicaid spending. The state portion is approximately 40%.
Source: Comparison of MC+/Medicaid Mandatory Eligibles and Services with Optional Eligibles and Services, Department of Social Services, February 5, 2003

Programs

Missouri Medicaid provides services to recipients through several programs, including Medicaid for Children, SCHIP, Medical Assistance for Families, MC+ for Pregnant Women and Newborns, Medicaid (serves the elderly, blind, and disabled), and Medical Assistance for Workers with Disabilities. In Missouri, the Division of Medical Services within the Department of Social Services administers the Medicaid program. The following chart illustrates enrollment figures and expenditures for Missouri Medicaid in fiscal year 2002, and is divided into four types of eligibility groups.

Missouri Medicaid Enrollment and Expenditures - Fiscal Year 2003

	Enrollees	Annual Expenditures	Monthly Expenditures per Enrollee
Elderly	**80,404**	**$1,192,703,142**	**$1,236**
Disabled	**133,070**	**$1,877,824,655**	**$1,176**
Adults			
Pregnant Women	15,917	$70,135,712	$367
Adult MAF	164,790	$390,603,841	$198
General Relief	2,936	$17,365,891	$493
Refugee	121	$286,239	$197
1115 Adult	11,315	$4,653,028	$34
TOTAL ADULT	**195,079**	**$483,044,711**	**$206**
Children			
Children - Ages 0-18	414,609	$715,033,700	$144
Foster Care	12,119	$75,572,982	$520
Children in State Custody	10,961	$109,347,990	$831
DYS - GR	576	$2,217,650	$321
Child Welfare	583	$3,926,912	$561
Kids w/ Develop Disabilities	187	$3,795,333	$1,691
CHIP	80,435	$96,843,995	$100
TOTAL CHILDREN	**519,470**	**$1,006,738,562**	**$162**
GRAND TOTAL	**928,023**	**$4,560,311,070**	**$410**

Source: Missouri Department of Social Services, Division of Medical Services

Missouri's Medicaid expenditures in these four groups can be contrasted with national averages and total spending for the same four groups, as reported in 1998 and illustrated in the following chart:

National Average Medicaid Spending by Category, 1998		**Total National Medicaid Spending by Category, 1998 ($billion)**	
Children	$1,225	Children	$24.5
Adult	$1,892	Adult	$16.0
Blind and disabled	$9,585	Blind and disabled	$67.7
Elderly	$11,235	Elderly	$46.1
Source: Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.* *Source (21)*		**Source:** Kaiser Commission on Medicaid and the Uninsured. Bruen and Holahan, *Slow Growth.*	

Medicaid for Children

Children receive health care coverage through either a state's regular Title XIX Medicaid program, or through the state's Title XXI Children's Health Insurance Program (SCHIP). The Missouri SCHIP is described in the next section.

Federal Title XIX Medicaid coverage requirements for children vary by age. States must cover children up to the age of six who have family incomes below 133% of the federal poverty level. States are also required to cover children from the ages of six through 18* who have family incomes below 100% of the federal poverty level. In Missouri children are eligible for Medicaid coverage under Title XIX using the following guidelines:

- Newborns up to the age of one with family incomes up to 185% of the federal poverty level;
- Children ages 1 through 5 with family incomes up to 133% of the federal poverty level;
- Children ages 6 through 18 with family incomes up to 100% of the federal poverty.

Currently in Missouri, children above these limits with family incomes up to 300% of the federal poverty level may qualify for health care coverage through the SCHIP program.

Missouri law does not require a resource test for Medicaid for children, although federal law gives states the option of establishing a resource test. Federal law requires optional resource tests to be no more restricted than the state AFDC level as of July 16, 1996, which was less than or equal to $1,000 in countable resources per family[20]. Resources that are exempt from

* Throughout this report, when coverage is described as being "through" a particular age, the individual is covered throughout the year in which coverage ends. For example, children are covered "through" the age of eighteen. This means that a child's coverage ends when he or she turns 19, or that it lasts until the child is 18 years and 364 days old.

"countable assets" include the home and 40 acres surrounding it; $1,500 equity in one vehicle; one burial plot per family member; property used in the course of business or employment; and household furnishings.

SCHIP – MC+ for Kids

The State Children's Health Insurance Program in Missouri is a subgroup of the MC+ program and is called the MC+ for Kids program or Title XXI. The Balanced Budget Act of 1997 established Title XXI of the Social Security Act creating the State Children's Health Insurance Program (SCHIP). The goal of this program was to help states expand Medicaid coverage to uninsured, low-income children and is a completely optional program.

As an incentive to states to create an SCHIP program, the federal match rate for the program is higher than the match rate for Title XIX Medicaid for children. For state fiscal year 2004, the funding for the MC+ for Kids program was a 72.99% federal and 27.01% state match. This is a significant increase from the standard Medicaid match of 61.5% federal and 38.5% state match. Additionally, federal law requires states that do not spend their annual federal SCHIP allocation to redirect a portion of unspent funds to other states that have spent their SCHIP allocation. Missouri has received significant amounts of these "redirected" funds. In fiscal year 2004, Missouri's SCHIP allotment was $41.9 million. Missouri received an additional $26.6 million in SCHIP funds that were redirected from other states bringing the total amount of federal SCHIP funds appropriated for fiscal year 2004 to $68.5 million.

States are required to first determine whether a child qualifies for coverage through the Medicaid for Children program before determining SCHIP eligibility. To enroll in a MC+ for Kids program, children must be under the age of 19, have a family income below 300% of the federal poverty level, and have a family net worth less than $250,000.

Missouri's SCHIP program has three tiers of eligibility. Children with family incomes up to 185% of the federal poverty level who do not otherwise qualify for Medicaid through a non-SCHIP group are eligible for MC+ for Kids and are not required to pay a co-payment or premium. Children with family incomes between 186% and 225% of the federal poverty level must pay a $5 co-payment per professional visit. In addition to the participation requirements outlined above, children with family incomes between 226% and 300% of the federal poverty level must also be uninsured for 6 months or have no access to other health insurance coverage for less than $331 per month. These children pay a $9 co-payment for prescription drugs and a $10 co-payment for each professional visit. They also pay a monthly premium that ranges from $59 to $225 per month, depending on the family's size and income.[21]

According to the Centers for Medicare and Medicaid Services 13 states including Missouri have SCHIP income limits above 200% of poverty. Missouri, Connecticut, Maryland, New Hampshire, and Vermont have an income limit of 300% of poverty. New Jersey has the highest limit, 350% of poverty. Ten states have income limits below 200% of poverty. The state with the lowest income levels was North Dakota with a limit of 140% of poverty for all children under age 19. When Wyoming first implemented SCHIP in 1999, it used SCHIP funds to expand Medicaid to cover children age 16 through 18 with family income up to 133% of

poverty. At that time Wyoming Medicaid had an income limit of 133% of poverty for children ages 0 through 5 and 100% of poverty for children ages 6 through 15[22]. Effective October 1, 2003 Wyoming increased its SCHIP income limit to 185% of poverty.

Medical Assistance for Families

Missouri's Medicaid program provides medical assistance for low-income parents through two programs: Medical Assistance for Families and Transitional Medical Assistance. Medical Assistance for Families is the name of the Missouri Medicaid program that provides assistance for families that have incomes at 77% of the federal poverty level or below. Medical Assistance for Families provides coverage for children under the age of 19 and their parents who live with them.

Federal law requires states to cover Medical Assistance for Families recipients with incomes up to the state's AFDC income level as of July 16, 1996. In Missouri, this is equal to between 18 and 23 % of the federal poverty level. (2, 41) As mentioned above, Missouri covers individuals with incomes up to 77% of the federal poverty level at its option. Before July 1, 2002, Missouri covered individuals with incomes up to 100% of the federal poverty level.

Missouri imposes no asset test on recipients of Medical Assistance for Families. However, Federal law allows states the option of imposing an asset test as long as it is no more restrictive than the state's AFDC level as of July 16, 1996, which was less than or equal to $1,000 in countable assets. Resources that are exempt from "countable assets" include the home and 40 acres surrounding it; $1,500 equity in one vehicle; one burial lot per family member; property used in the course of business or employment; and household furnishings.

Esra Murray of the Family Support Division testified that applicants for Medical Assistance for Families are checked against Child Support Enforcement lists and referred for child support services if necessary. Families in which one parent is absent are automatically referred to child support enforcement services in the pursuit of medical support. She testified that approximately 90% of Medical Assistance for Families recipients also receive Food Stamps.

Low-income parents in welfare-to-work families are also eligible for Medicaid. This group of recipients, known in Missouri as Transitional Medical Assistance, becomes eligible for up to 12 months because they are ineligible for Medical Assistance for Families due to increased earnings. The family must have been eligible for Medical Assistance for Families in three of the six months prior to becoming ineligible due to increased earnings. Income during the second six months of the transitional medical assistance coverage period cannot exceed 185% of the federal poverty level.[23] This is a mandatory coverage group, and federal law prohibits the use of a resource test during the coverage period.[24] Missouri Medicaid also covers an additional year of extended transitional medical assistance for families who have incomes at or below 100% of poverty. This is an optional coverage group.

MC+ for Pregnant Women and Newborns

Missouri MC+ for Pregnant Women and Newborns provides Medicaid coverage for pregnant women and their newborn children who have family incomes up to 185% of the federal poverty level. The federal requirement for this eligibility group is up to 133% of the federal poverty level. Missouri Medicaid deems the income of a parent whose minor child is a pregnant woman to the pregnant woman for purposes of determining financial eligibility for this program. The coverage includes sixty days of postpartum coverage for the mother, and MC+ coverage for one year for the child. A woman's coverage continues throughout her pregnancy and through the postpartum period once she is determined to be eligible, despite any subsequent increases in her income.[25] Even though federal law allows states to implement a resource test for pregnant women, Missouri law does not require a resource test for this category of Medicaid eligibility. Federal law states a resource test can be no more restrictive than the July 16, 1996 limit for AFDC of $1,000.[26]

Income Eligibility Levels for Pregnant Women as a Percent of Federal Poverty for the 50 States including the District of Columbia July 2003

Coverage for Pregnant Women, Percent of Federal Poverty Level	Number of States
133%, Federal Minimum	11
150%	4
185%, Including Missouri	19
200%	13
235%	1
250%	2
275%	1
National Weighted Average 186%	

Source: State Health Facts Online, The Henry J. Kaiser Family Foundation. www.statehealthfacts.kff.org/

Medicaid

Medicaid is the general term for medical assistance provided to elderly, blind, and disabled individuals. Individuals who receive Medical Assistance, Nursing Care, Home and Community Based Services, General Relief, Supplemental Aid to the Blind, Blind Pension, and Adult Supplemental payments receive Medicaid services on a fee-for-service basis.

Dual eligibles are a significant sub-group of the aged and disabled Medicaid recipient population. Dual eligibles are individuals who qualify both for Medicaid and for Medicare. If Medicare recipients who qualify as QMBs or SLMBs also meet the Medicaid income and resource guidelines, they can receive Medicaid. The state Medicaid program is required by federal law to pay Medicare premiums and co-insurance, as well as Medicare deductibles for individuals who meet income guidelines.

In Missouri, there were 161,000 dual eligibles in 2002, which represented 14% of the total Medicaid population, but 64% of the aged and disabled enrollees[27]. Nationally, there were 7,200,000 dual eligibles in 2002, which was 14% of all enrollees and 58% of aged and disabled enrollees. Missouri spent $1.9 billion on dual eligibles in 2002[28].

The aged population is considered to be those age 65 and older. The income threshold for the elderly or aged population who are living in their homes is currently 90% of the poverty level or $674 per month for one person, and $909 per month for a couple. The asset limit is $1,000 for an individual and $2,000 for a couple. Individuals who have incomes that exceed these limits can spend down to the eligibility limit. Marie Fann from the Family Support Division testified that this spenddown amount can be met by either providing receipts for medical expenses and bills that the individual has paid, or by paying the spenddown amount by check or direct deduction from the individual's account.

Individuals who are receiving Medicaid in nursing facilities are not subject to an absolute income limit; rather their monthly income goes first to pay for the cost of care, and then Medicaid pays the balance. The asset limits for nursing home residents are also $1,000 for a single person and $2,000 for a couple.

Roger Rome of the Family Support Division testified about division of assets. Division of assets allows an institutional spouse to be admitted to a nursing home while not impoverishing the spouse who stays at home, also know as the "community spouse." Division of assets is determined by an assessment that is conducted in the month that the institutionalized spouse enters the institution in a Medicaid certified bed and is expected to be there for at least 30 days.

Division of assets is a compilation of all the assets the couple currently owns. All exempt assets are transferred to the community spouse including a car, home, and an irrevocable prepaid burial plan. The non-exempt resources are then divided in half, and the community spouse is entitled to one-half the non-exempt assets or up to the annual maximum Community Spouse Resource Allowance (CSRA).[29] The CSRA was originally set by federal law and is adjusted annually based on the Consumer Price Index.[30] For 2004, the maximum CSRA is $92,760, and the minimum is $18,552.[31] If one-half of the assets do not equal at least $18,552 for the community spouse, assets from the institutionalized spouse are deemed to be available to the community spouse to reach that level. The community spouse's share may also be adjusted to meet the Community Spouse's Monthly Income Allowance (CSMIA), the Minimum Monthly Maintenance Needs Allowance (MMMNA), and excess shelter expenses. The community spouse can also request additional assets in hardship circumstances. After all of the adjustments are made, the institutional spouse must spend down any assets that remain in his or her share to $1,000. Medicaid covers medical care, plus the cost of the nursing home for the institutionalized spouse.

Individuals who are receiving home and community-based services paid for by Medicaid have a monthly income limit of $965. This income limit is only applicable to the individual needing the services. Home and community based service recipients also go through the division of assets described above, and then the asset limit is $ 1,000 for the person needing services.

Disabled Individuals

Individuals with disabilities represent 13% of Missouri's Medicaid population, or just less than 120,000 individuals. However, in fiscal year 2002, individuals with disabilities represented the

largest group of Medicaid expenditures, with 40% of the Medicaid budget spent on services for these individuals[32].

Denise Cross, Director of the Family Support Division of the Department of Social Services testified that there are two primary pathways for individuals with a disability to become qualified for Medicaid. The first pathway applies to individuals who are receiving SSI or Social Security Disability (SSD) payments. The Social Security Administration determines disability for purposes of these programs, and Missouri's Medicaid program accepts the disability determination for purposes of Medicaid eligibility. According to Denise Cross, 88% of the disabled population receiving Medicaid also receives SSI or SSD benefits.

In Missouri, the Department of Elementary and Secondary Education (DESE) is responsible for conducting disability determinations for SSI and SSD. Section 161.182 requires DESE to contract with the federal government to carry out the provisions of the Social Security Act with respect to disability determinations. The Social Security Administration outlines five questions that must be used by entities conducting disability determinations for purposes of SSI eligibility. First, the agency asks whether the individual is working. If the individual is working and his or her earnings are more than $800 per month in 2003, he or she cannot be considered disabled. The next question is whether or not the individual's condition is severe. A condition is considered to be severe if it interferes with basic work-related activities. The evaluator then looks at the Social Security Administrations' list of disabling impairments to determine whether the applicant's disability appears on the list. The listing contains impairments to each of the major body systems that are so severe that an impaired individual is automatically considered disabled. If the individual's condition is not on the list, the condition is evaluated to determine whether it is comparable in severity to a listed impairment. If the condition is either on the list or comparable, the individual's claim for benefits is approved. If the condition is severe but not the same severity level as an impairment on the list, the evaluator determines whether the impairment interferes with the individuals' ability to do the work the individual did in the last 15 years. If the impairment does not interfere, the claim will be denied. If the impairment does interfere with the individual's ability to do work, the evaluation moves to the final step. The final question asked in the evaluation is whether the individual can do any type of work. The evaluator considers the individual's age, education, work experience and transferable skills. If the evaluator determines the individual cannot do any other kind of work, the claim will be approved. If the individual can do other work, the claim for SSI benefits will be denied.[33]

The second pathway for an individual with a disability to qualify for Medicaid is to be determined disabled by the State of Missouri. Eleven percent of individuals receiving Medicaid because of a disability became eligible through this pathway. Denise Cross testified that disability determinations are made by physicians who contract with the Department of Social Services, using the Social Security Administration's listings.

All individuals who are determined to be disabled must meet income and asset requirements in order to be eligible for Medicaid. In recent years, the fastest growing segment of Missouri's Medicaid population has been individuals with disabilities. Chris Rackers of the Division of Medical Services testified that the disabled Medicaid recipient population had the highest growth rate in fiscal year 2003. Officials from the Department of Social Services explained that the

growth in the disability category is due to several factors, including the aging of the population and changes in the SSI program on the federal level in 1996. These changes resulted in restrictions on eligibility for certain children, and for individuals whose primary health condition was due to alcohol or substance abuse. The Department speculates that these individuals have gradually gotten sicker and have become eligible for Medicaid as their health deteriorated.

Medical Assistance for Workers with Disabilities

Enacted in 2002, Medical Assistance for Workers with Disabilities was created in Missouri in response to the federal Ticket to Work and Work Incentives Act of 1999. This program allows working individuals with disabilities to maintain Medicaid coverage even if their income and resource levels exceed the limits. The asset limits are based on the levels established for the elderly, blind, and disabled population. Denise Cross of the Department of Social Services, Family Support Division testified that traditionally these individuals would quit their jobs or be under-employed in order to maintain their health care coverage under Medicaid.

The financial eligibility requirements for the Medical Assistance for Workers with Disabilities program are outlined in Section 208.146, RSMo. They are as follows:

Gross income of 250% or less of Federal Poverty Level

- Income of the person's spouse up to $100,000 is excluded, as is income of person's children
- Individuals with incomes greater than 250% of Federal Poverty Level must pay a premium

Exempt assets:

- Spousal assets up to $100,000, one-half of marital assets, and assets excluded pursuant to 208.010 RSMo
- Retirement accounts
- Medical expense accounts set up through the individual's employer
- Family development accounts
- PASS plans
- Independent living development accounts

Individuals who have access to more cost-effective health insurance through an employer must participate in the employer-sponsored plan, but the Department of Social Services will pay the individual's premiums, co-payments and other costs associated with participation in the program.

- Individuals with incomes over 150% of the Federal Poverty Level must pay a premium for participation in the program. The premiums are as follows:
  - For individuals with incomes between 151% and 175% FPL, 4% of income at 163% FPL
  - For individuals with incomes between 176% and 200% FPL, 5% of income at 185% FPL;
  - For individuals with incomes between 201% and 225% FPL, 6% of income at 213% FPL; and
  - For individuals with incomes between 226% and 250% FPL, 7% of income at 238% FPL.

Kirsten Dunham, Senior Policy Analyst for Paraquad testified that Medical Assistance for Workers with Disabilities gives individuals an incentive to return to work and allows them to contribute to the cost of their healthcare. Without the program, many disabled individuals would return to regular Medicaid and would not be employed.

OTHER STATES

In recent years, every state has addressed growing fiscal pressures, particularly in state Medicaid programs. A recent survey conducted by the Kaiser Commission on Medicaid and the Uninsured found that every state in the nation utilized some type of Medicaid cost containment in fiscal year 2003, and that every state intends to do so again in fiscal year 2004. States have chosen to address these issues in a wide variety of ways that make changes to both the services provided by the state Medicaid program, and the individuals that are eligible by the state Medicaid program. Cost containment strategies undertaken by states in fiscal years 2002 through 2004 included controlling drug costs, reducing or freezing provider payments, reducing or restricting eligibility, reducing benefits, and increasing co-payments.

Pharmaceuticals

The survey conducted by the Kaiser Commission on Medicaid and the Uninsured found that cost containment trends for drug benefits in fiscal years 2003 and 2004 included the development and implementation of preferred drug lists, states seeking supplemental rebates from pharmaceutical companies, and the increased use of beneficiary co-payments.[34] The two cost containment activities that were most often used by states in fiscal years 2003 and 2004 were increasing the number of drugs subject to prior authorization requirements and implementing preferred drug lists. A summary of other states' cost containment measures for pharmaceuticals in fiscal years 2003 and 2004 is included in Appendix B.

Change In Benefits

Between fiscal years 2002 and 2004, 35 states have reduced Medicaid benefits in at least one of those years. Benefit reductions focused on optional services that states provide. Many of the states making benefit reductions focused on adults enrolled in the Medicaid program, but several states made significant changes by restructuring the state Medicaid program. Most states eliminated one or two of the optional benefits for a particular population, but four states eliminated several optional services. A chart outlining states' cost containment strategies regarding Medicaid benefits is included in Appendix B.

- ***Connecticut*** eliminated chiropractic services, naturopathic services, podiatry, occupational therapy, physical therapy, speech therapy, and psychology services for all adults. These changes affected about 100,000 people.
- ***Massachusetts*** eliminated prosthetics, orthotics, eyeglasses, chiropractic services, and dentures for all adults in fiscal year 2003. These changes affected an estimated 513,000 people. Prosthetic and orthotic coverage was restored for fiscal year 2004.
- ***Utah*** eliminated podiatry, speech therapy, audiology, occupational therapy, physical therapy, and vision care for all adults, which affected 60,000 people. Coverage for speech therapy, audiology, occupational therapy, physical therapy, and limited coverage for podiatry services were restored in fiscal year 2004.

Oregon restructured its state Medicaid program, the Oregon Health Plan (OHP) in 2003. Adults enrolled in OHP Standard include parents of children enrolled in Medicaid and SCHIP, childless adults, seniors, and disabled individuals with incomes at or above 75 % of the federal poverty

level. Many optional services for this group were eliminated in 2003, including vision, dental, non-emergency medial transportation, durable medical equipment, mental health services, and chemical dependency services.

Change In Eligibility

Several states also made changes to eligibility categories that effectively eliminated coverage for certain groups. In fiscal year 2003, these states included Missouri, Nebraska, Massachusetts, Tennessee, Michigan, and Connecticut. In each of these states except Massachusetts the eligibility changes were either blocked or delayed by court action. Most of these eligibility changes effected adults. In fiscal year 2004, Massachusetts, Nebraska, and Texas eliminated coverage for certain categories.

A total of 17 states made changes to eligibility requirements in fiscal year 2003 or fiscal year 2004 that affected children. These changes included reducing the amount of earnings disregarded, changing the treatment of household composition for eligibility, counting parental income for pregnant minors, decreasing income eligibility levels, and eliminating coverage for 19 to 20-year-olds. States are also charging children and families premiums as a condition of coverage. The SCHIP program allows states to charge premiums for certain groups, but states must obtain a waiver to charge a premium to children and families participating in the regular Medicaid program.

Federal Medicaid law allows states to charge co-payments to beneficiaries, but specifies that any co-payment must be "nominal," which is generally accepted to mean a maximum of $3.00 per service. Several states have implemented co-payment requirements as a cost containment measure, with many states implementing the maximum $3.00 co-payment. States added co-payment requirements to prescription drugs, non-emergency transportation, hearing, vision, dental, therapies, physician office visits, ambulatory services, outpatient hospital visits, durable medical equipment, lab and x-ray services, physician office visits, hospital ER visits for non-emergency services, psychology services, podiatry services, hearing tests and hearing aids, and FQHC services. Most states applied new co-payments to adult populations or to specified groups of the adult population.

According to the Kaiser Commission on Medicaid and the Uninsured report, 25 states reduced or cut Medicaid eligibility in fiscal year 2003, including Missouri. In six states, these cuts and reductions were intended to eliminate large numbers of individuals from the Medicaid eligible population. However in each of these six states, implementation of the reductions or cuts have been delayed or stopped by court action. A chart outlining states' eligibility changes is included in Appendix B.

Cost Containment Strategies Considered by Other States

Florida, Iowa, and Vermont have looked into the use of health care savings accounts within Medicaid. Under this program states place a set amount of funds into an enrollees account to purchase health care services. Then, beyond a certain amount, individuals are responsible for a portion of the costs. The idea is to help patients be more cost-conscious in their use of health care services[35].

Nebraska eliminated a system called "stacking". Using stacking, the state determined eligibility by dividing total household income by the number of individuals in the household. The result was that people were often individually eligible for Medicaid when their family, as a unit, was not. Nebraska estimates that 7% of the 132,500 children enrolled in Medicaid come from families with incomes that are actually above the state's eligibility level of 185% of the federal poverty level[36].

Oklahoma decided to reduce eligibility in the following ways:

- Ages 6 – 18, from 185% FPL to 115% FPL
- Ages 1 – 5, from 185% FPL to 133% FPL
- Elderly and disabled from 100% FPL to 80% FPL.

Changes for Oklahoma were targeted to take effect in November 2002 but were delayed due to a lawsuit filed by an advocacy group that has since been dismissed.[37]

MANAGED CARE

The Medicaid managed care program in Missouri is referred to as the MC+ Managed Care program. It is a medical assistance program for low-income families, pregnant women, children, and uninsured parents, who are required to enroll in their choice of seven managed care plans. MC+ Managed Care started in Missouri in 1995. Missouri is one of 48 states that currently have a Medicaid managed care program. Currently only 37 counties, all of which fall along the I-70 corridor, are participating in the MC+ Managed Care program. Donna Checkett of the Missouri Health Care Plan testified that approximately 45% of Medicaid beneficiaries in Missouri are enrolled in a managed care plan.

The managed care philosophy establishes a main point of contact, a primary care doctor, for each patient. The primary care doctor offers a "medical home" for the member. The patient establishes a relationship with the medical home and uses it as a first stop in the health care process. In some cases, primary care doctors act as a gatekeeper who refers the member to other providers based on need of care. The goal of implementing MC+ Managed Care was to control costs by capitating rates to health plans, improve access, assure quality of care, and establish a primary care doctor for coordinating a patient's care. As of September 2003, 431,715 members were enrolled in Missouri's MC+ Managed Care program.

As a condition of receiving benefits in the Medicaid program children, pregnant women, TANF recipients, and children and youth in custody of the state are mandated to enroll in MC+ Managed Care if they reside in the managed care areas.

It is estimated that the state of Missouri has realized $200 million savings under the MC+ Managed Care program during 2002 alone[38]. Savings since the program's inception have been restricted to 5 - 10% each year as a result of federal laws not allowing payments to Medicaid health plans to be higher than 95% of fee for service. Health plans are able to achieve these savings in part due to the management of patient care that only allows the patient to participate in specialist visits that make sense for their medical condition. Other savings comes from control of lengthy hospitalizations and establishment of preferred drug lists not in place under Medicaid fee for service.

MISSOURI MANAGED CARE PROGRAMS AND ENROLLMENT			
As of June 30 of Each Year (Point-in-Time Data)			
Year	Eligibles (Millions)	Enrollees (Millions)	% of Total
1998	30.9	16.6	54%
1997	32.1	15.5	48%
1996	33.2	13.3	37%
1995	33.4	9.8	27%
1994	33.6	7.8	22%
1993	33.4	4.8	14%
1992	30.9	3.6	12%
1991	28.3	2.7	10%

***Source**: Center for Medicaid and Medicare Services, Office of Managed Care Medicaid National Summary Statistics: (HCFA-2082 Report) National summary of Medicaid managed care programs and enrollment as of June 30 of each year (Washington, D.C.: CMS, 2001). See http://www.hcfa.gov/medicaid/msis/2082-11.htm (Accessed November 2001).*

Each of the 48 states with a Medicaid managed care program has chosen which eligibility groups to enroll in its managed care program. Although Missouri does not currently enroll the disabled population in a managed care program, according to the Centers for Medicare and Medicaid Services and Kaiser Commission on Medicaid and the Uninsured, 36 states enroll some people with disabilities into managed care. Six states, Arizona, Maryland, New Mexico, Oregon, South Dakota, and Tennessee, enroll more than three-quarters of their beneficiaries with disabilities in managed care[39].

The benefits and potential drawbacks of managed care tend to be the same for Medicaid as they are in the private sector.

Possible Benefits of Managed Care[40]

- A managed care system guarantees access to a network of physicians of differing specialties. In traditional fee-for-service Medicaid, the onus is on the enrollee to find physicians willing to accept Medicaid recipients.
- Managed care may encourage efficient and appropriate use of services leading to better coordination and quality for people with high medical needs.
- For Medicaid, health plans are able to hire more physicians and other clinicians with the expertise necessary to manage health care in an efficient and effective manner.

Possible Downfalls of Managed Care[41]

- Although many health plans actually pay primary care doctors rates that are above the Medicaid fee for service rate, as opposed to negotiating discounts, some providers may nevertheless not want to participate for reasons such as low reimbursement. If there is a provider shortage, as in many rural areas, Managed Care Organizations may not be able to meet Department of Insurance access regulations and will not be able to be licensed to enter the market.

- In any capitated arrangement, especially in the elderly and disabled populations, there is a fear that managed care will result in under-treatment.

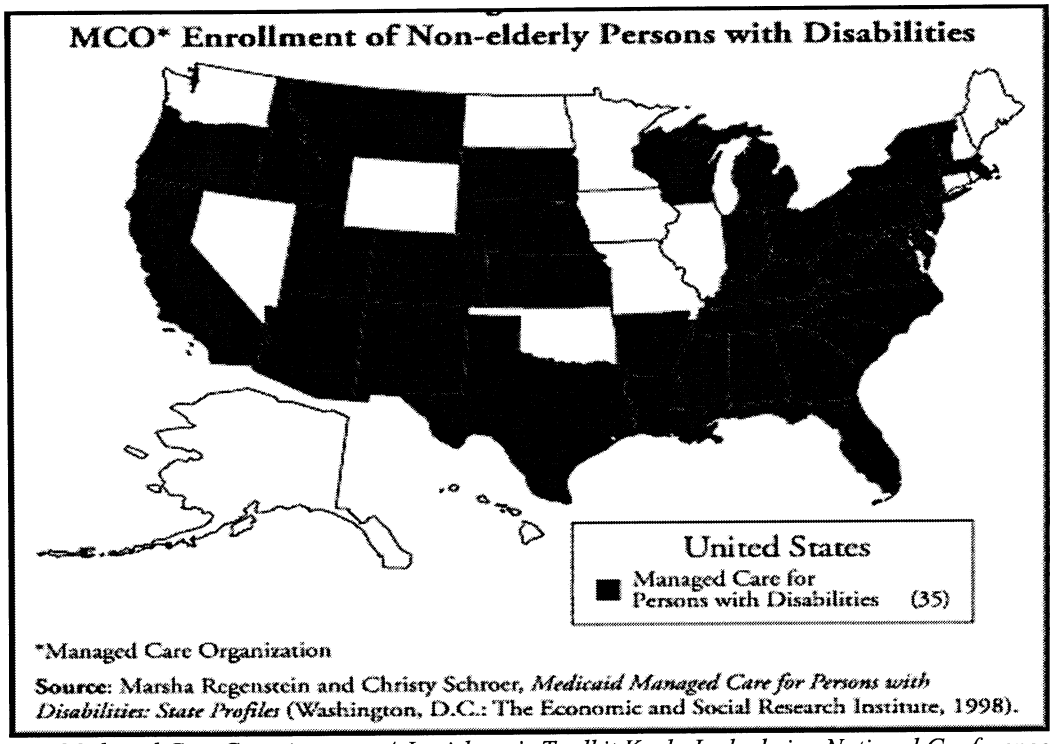
Enrolling the aged and disabled in Medicaid managed care can be complicated by dual eligibles. States cannot manage Medicare spending or service delivery without a Medicare demonstration waiver, and often are challenged by having control over only a limited number of services for dual eligibles.[42]

Other State's Experiences with Managed Care

- **Provider shortages**, which limit managed care penetration, are a major reason that Alaska and Wyoming, two very rural states, do not have managed care. This also has been a factor in the withdrawal of health plans from Medicare + Choice and state Medicaid programs in northern New England and West Virginia.[43]
- **Changes in enrollment.** Several states have enrolled new populations in managed care. New Mexico, one of six states to enroll more than 75 percent of the disabled population, enrolls all people with disabilities in one of three mainstream capitated plans. Michigan has a mandatory capitated program for all Medicaid recipients and a special voluntary program targeted at children with special health care needs. Washington tried, then abandoned, managed care for people with disabilities. In 1998, Washington moved all people with disabilities from managed care arrangements to fee-for-service after utilization and costs increased and health plans became reluctant to participate in the plan. (21)
- **Changes in Services Covered.** In the early 1990s, Massachusetts became the first state to implement a comprehensive behavioral managed care program. The shift successfully slowed the growth in behavioral health cost. Carve-outs do not always result in savings. Some states chose to capitate some care and cover more serious conditions in fee-for-service. Hawaii and New York, for example, both use partial carve-outs for more intensive mental health treatment, leaving basic mental health benefits in their standard capitated plans. Missouri also carves out intensive mental health services.

Opportunities with Managed Care

The largest opportunity to expand managed care coverage is to include the elderly, the institutionalized, and the community-based permanently and totally disabled. Currently, this group has the highest cost and most complex care. The Missouri Association of Health Plans do not recommend including long-term institutionalized Medicaid beneficiaries in managed care. The most important aspect of this group shifting into managed care is to ensure the quality of care is not compromised and the rates are set at the proper level. There are numerous examples from across the country of how this can be achieved. In addition, CMS has many federal requirements that must be met in order to ensure vulnerable populations in managed care are protected.



Source: Medicaid Cost Containment: A Legislator's Toolkit Kayla Ladenheim, National Conference of State Legislatures, March, 2002.

According to a Kaiser Family Foundation report, as of March 2001, 36 states enrolled some people with disabilities into managed care, and 1.6 million people with disabilities were covered under a Medicaid managed care plan as of 1998. A majority of these enrolled did so under a mandatory enrollment plan.[44]

The second most significant opportunity to expanding managed care coverage is to broaden coverage areas for children and families. Currently, 37 counties and the city of St. Louis offer Medicaid managed care.

Only two states have managed care statewide, Tennessee and Arizona. Some states have faced criticism of a failed managed care system. In rural areas the access to doctors in a managed care system may not be possible. In these situations some states have moved to an enhanced Primary Care Case Management (PCCM) system. A PCCM system relies on a case manager to locate, coordinate, and manage services for Medicaid enrollees. The primary care case manager can be a physician, a physician group practice, a physician assistant, or a nurse practitioner. While the patient maintains contact with one primary care case manager, the patient is not restricted to picking an in-network specialist. PCCM programs are paid a per-member, per-month case management fee and patient visits are paid on a fee-for-service basis. [45]

Rhode Island has focused its efforts on moving SSI eligible children and children in foster care into managed care. In 2002, Rhode Island realized a significant savings due to the enrollment of foster children into managed care by decreasing the number of hospital days by one-third. The state anticipated similar significant savings by enrolling SSI eligible children in managed care in 2003.[46]

Oklahoma has measured results from enrolling their aged, blind, and disabled population in a Medicaid managed care model. Five hundred and thirty eight enrollees were polled and the following information was discovered that managed care for the aged, blind, and disabled resulted in

- A 4% savings in total medical and administrative costs.
- When the ten most costly enrollees were excluded from the data, the overall net cost savings were 17% when compared to the fee for service program.
- Sixty-one percent polled said their care was better under managed care.[47]

The Balanced Budget Act (BBA) of 1997 allows states to mandate enrollment in managed care for some Medicaid recipients without a federal waiver. Certain groups such as dual eligibles and children with special health care needs still require a federal waiver for mandatory enrollment in Medicaid managed care. Individuals subject to mandatory enrollment must have a choice, whether that choice is between two or more managed care entities, one managed care entity and a PCCM, or one managed care entity and fee-for-service providers. Beneficiaries must also be permitted to disenroll at any time for cause. Managed care enrollment is not required to be statewide. All benefits listed in the Medicaid state plan must be covered for all eligible recipients, but the benefits offered through the managed care plan are not required to be uniform. Any benefits guaranteed by the Medicaid state plan, but not covered by a Medicaid managed care entity, will be provided by the state on a fee-for-service basis.

LONG TERM CARE

Medicaid is a significant payer of long-term care services in the United States consisting of 46% of the total dollars spent on nursing home care as of 1998.[48] Medicaid also comprises a significant share of long-term care services in Missouri. It is projected that Missouri's Medicaid program will spend over one billion dollars in 2003 on nursing home care.[49]

Nationally, there is a shifting of costs from nursing home care to home and community based care. From 1992 to 1998 the percentage of Medicaid spending on home and community based care as a percentage of total Medicaid long-term care spending has increased from $44 billion or 15% to $59 billion or 25%.[50]

The first baby boomers will begin turning 65 in 2010. Our aging population coupled with the fact that Americans are living longer due to health care advances presents unique challenges to state governments and their Medicaid programs. Nationally, cost containment strategies for long-term care expenditures are varied. Suggestions include expanding home and community based services, providing acute and long-term care services through managed care programs, encouraging private long-term care insurance, reducing "Medicaid Estate Planning," and maximizing federal financing.[51]

The committee heard testimony from individuals with different perspectives on long term care in Missouri, including the administrator of a facility that receives one of the lowest reimbursement rates in the state, representatives of the two major nursing home organizations, and individuals representing a Program of All-Inclusive Care for the Elderly (PACE). The committee also heard testimony about the nursing home reimbursement methodology used in Missouri as well as the method used by the Department of Health and Senior Services to determine level of care for purposes of admission to a nursing home or certification for home and community based care.

Nursing Home Reimbursement Rates

Testimony presented to the committee raised questions about nursing home reimbursement rates and the methodology for determining rates in Missouri. As a result, officials from the Department of Social Services provided testimony about the nursing home reimbursement methodology.

Margie Mueller and Becky Rucker of the Division of Medical Services testified regarding Medicaid reimbursement for nursing facilities in Missouri. The current reimbursement system is the result of a task force commissioned in 1993 by former Governor Mel Carnahan. The intent of the reimbursement system was to emphasize quality patient care. It was implemented on January 1, 1995.

The nursing facility reimbursement system classifies expenses into one of four cost center components. These cost center components are patient care, ancillary, administration, and capital.

- The patient care cost center accounts for expenses related to direct patient care, and includes supplies, nursing services, and dietary costs.

- ❖ The ancillary cost center captures services that support patient care, such as physical therapy and laundry services.
- ❖ The administration cost center includes fixed expenses related to the overall administration of the facility.
- ❖ The capital cost center includes expenses related to the ownership of the building and is calculated using a fair rental value system rather than actual costs.

Each cost center has a ceiling set at 120% of the component median for patient care and ancillary centers and at 110% of the component median for the administration center. The ceiling for the capital cost center is fair rental value. The administration and capital cost centers are also subject to an 85% minimum utilization adjustment. Currently, 1992 cost reports are the base year for the reimbursement system, and these rates are used to establish medians and ceilings. Medicaid rates have been adjusted by the legislature to reflect inflationary increases or changes in the minimum wage.

Several individuals representing nursing facilities testified about the nursing facility reimbursement rate. A representative from the Crestview Nursing Home in Bethany, Missouri suggested basing the Medicaid reimbursement rate at least partially on the acuity level of the patients in the facility. A national survey of nursing home reimbursement rates indicated that in 1998, 30 states considered acuity level (also referred to as "case mix") in some manner when determining nursing home reimbursement rates.

Denise Clemonds and Larry Rohrbach of the Missouri Association of Homes for the Aging, a group of not-for-profit facilities, stated that nursing facilities have experienced cost increases in several areas in recent years. These increases include the cost of liability insurance, increases in pay for nurses in order to retain them, and costs associated with federal and state mandates such as HIPAA. Ms. Clemonds and Mr. Rohrbach suggested looking at the acuity level of patients in a nursing facility as a component of the reimbursement methodology.

Earl Carlson and Tom Crawford of the Missouri Health Care Association, a group that represents 350 for-profit and not-for-profit nursing facilities in Missouri also testified about the current nursing facility reimbursement plan. They stated that the current plan was developed in 1994 and 1995, but that it has never been fully funded. As a result, re-basing the rate would be very expensive. They also testified that both community-based facilities and new private facilities are struggling to provide care for Medicaid patients.

States have flexibility in determining their reimbursement schemes for nursing facilities. As a result, the reimbursement rates vary from state to state. A complete list of state nursing facility reimbursement rates, along with a designation indicating whether the state takes acuity into account by using a case mix, is included in Appendix B.

Alexian Brothers Program of All-Inclusive Care of the Elderly (PACE)

On October 27, 2003 the House Interim Committee on Medicaid Cost and Containment toured the Alexian Brothers PACE facility located on South Grand in South St. Louis City. The main goal of the PACE program is to prove health, medical, and social services that makes is possible

for the elderly to remain living independently. The program in essence is designed to be an alternative to nursing home care.

The PACE program receives a capitated payment each month that is based on the number of participants enrolled that month. According to Deno Fabbre, the CEO of the PACE facility in St. Louis, the reimbursement for a Medicaid only participant is $3,534 per month while the reimbursement for a dual eligible participant is $2,376 per month from the state and $1,400 per month from the federal government. The state portion of this payment is subject to the roughly 60/40 state to federal funding match. While this amount seems high compared to the $98 reimbursed per day for nursing home care, the services covered are different.

The reimbursement referenced above is not supplemented by co-payments or deductibles and may include any or all of the following services:

- At-home health care services
- Transportation
- Doctor and nursing care
- Physical, speech, and occupational therapy
- Care from dentists, optometrists, audiologists, podiatrists, and psychiatrists
- Meals on site and nutritional counseling
- Prescription and over-the-counter medications
- Eye glass, dentures, and hearing aids
- Recreational therapy and activities
- Social services including individual and family counseling
- Spiritual counseling
- Health education and financial management
- Hospital services for acute or surgical needs
- Temporary or permanent nursing home care

When a participant begins using the PACE program, the Alexian Brothers team completes an evaluation to determine each participants needs. This evaluation includes the participation of the family. Most of the participants take advantage of the adult day care service at least three days per week. While they are at the facility an on-staff doctor or nurse sees them each day. This coordination of care allows for early detection and treatment of illness as well as knowledge of the full spectrum of care the participant receives. This allows for proper drug management, drug compliance, and coordination of treatments. The importance of correct drug management is outlined in an article in the *Geriatric Times*. September/October 2000 edition, Volume 1, Issue 3. According to the article, 28% of hospitalizations for elderly patients are related to medication misadventures or errors, and two-thirds of these hospitalizations are preventable. [52]

In order to receive services at the Alexian Brothers PACE, individuals must be at least 55 years of age, a resident in St. Louis City or St. Louis County, Certified by the state as eligible for nursing home care, be assessed by the PACE multidisciplinary team as being appropriate for program services.

Level Of Care

The Committee's visit to the PACE facility raised questions about the state's methodology for determining an individual's eligibility for long-term and home and community based care financed by Medicaid. In response to these questions, officials from the Department of Health and Senior Services testified about the level of care evaluation conducted in Missouri to determine an individual's functional eligibility for long-term or home and community based services.

Federal law requires Medicaid recipients seeking either home and community based services or admission to a nursing facility to be evaluated to determine the individual's level of care and whether nursing facility or home and community based care is medically necessary. According to David Morgan of the Department of Health and Senior Services, in Missouri an individual must have a level of care of 18 in order to receive Medicaid funded home and community based or nursing facility services. Federal law requires the level of care point total to be the same, whether the individual is receiving nursing facility care or home and community based care.[53]

The Department of Health and Senior Services conducts the level of care assessments and Mr. Morgan testified about how level of care is determined. Level of care is an assessment of an individual's ability to perform activities of daily living. Points are assessed in nine categories: monitoring, medications, treatments, restorative, rehabilitative, personal care, behavior and mental condition, mobility, and dietary.

Individuals seeking admission to a nursing facility must also complete a preadmission screening, an annual review, and have a physician's certification that they are in need of nursing facility care. Employees of the Department of Health and Senior Services conduct the level of care assessments. These employees have educational backgrounds in human services fields, and undergo three weeks of training after hiring and before seeing clients. Level of care is established and governed by state regulations of the Division of Medical Services and the Department of Health and Senior Services. The Department of Health and Senior Services' guide for determining level of care is included in Appendix B.

Department of Health and Senior Services – Division of Aging
Age by Level of Care for the Month Ending 10/31/03

In-Home Services for Clients in a Residential Care Facility

Source: Missouri Department of Social Services, Division of Medical Services

	Level of Care (LOC)										
	18	21	24	27	30	33	36	39	42	> 45	TOTAL
Age											
59 and Under	560	993	1276	945	460	153	52	19	6	2	**4466**
60 – 69	125	182	223	210	117	54	22	7	3	1	**944**
70 – 79	115	176	211	180	110	51	12	10	3	2	**870**
80 – 89	123	203	215	383	107	41	24	10	4	2	**1112**
90 and Over	45	68	81	91	41	23	11	5	1	1	**367**
TOTAL	**968**	**1622**	**2006**	**1809**	**835**	**322**	**121**	**51**	**17**	**8**	**7759**

Level of Care Point Score Statistics for Active Clients
for the Month Ending October 31, 2003

Home and Community Based Services Recipients

Source: Missouri Department of Social Services, Division of Medical Services

Points	Recipients
18	9,287
21	8,289
24	6,885
27	5,154
30	3,131
33	1,794
36	1,035
39	616
42	346
45	177
48	103
51	50
54+	67
Total	36,934
Mean	24.20 points

Medicaid Nursing Facility Users, Fiscal Years 1998 – 2003

NOTE: The average level of care for Nursing Facility users is estimated to be 36

Average number of users per month

Source: Missouri Department of Social Services, Division of Medical Services

Fiscal Year 1998:	**26,383**
Fiscal Year 1999:	**26,195**
Fiscal Year 2000:	**26,938**
Fiscal Year 2001:	**25,804**
Fiscal Year 2002:	**26,012**
Fiscal Year 2003:	**24,970**

PHARMACEUTICALS

Prescription drugs are an optional service under Federal law, but as of January 2003, every state in the nation participates in prescription drug coverage as part of their state Medicaid program.[54] According to the Urban Institute, Medicaid payments for outpatient pharmaceuticals rose over 16% annually between 1990 and 2000. This represents an increase from $4.8 to $21 billion, and the trend is likely to continue through the 2000s. [55]

State Medicaid officials in 38 states identified prescription drugs as one of the most significant factors contributing to Medicaid expenditure growth in fiscal year 2003.[56] As a result, Medicaid pharmaceutical programs are one area that states have focused on in their attempts to contain rising Medicaid costs. Pharmaceutical cost containment measures undertaken by other states during the fiscal years 2003 and 2004 are summarized in a report that is included in Appendix B.

Like many of its sister states, Missouri has experienced significant growth in its Medicaid pharmaceutical program in recent years. Missouri has also recently implemented several measures designed to help contain the rising costs associated with the pharmacy program. The following chart highlights the increase in Medicaid pharmaceutical expenditures in the last four fiscal years.

	FY00	FY01	FY02	FY03
Expenditures	$581,196,903	$675,241,928	$765,965,691	$876,383,919
FFS Eligibles	421,786	462,506	468,722	506,021
GR Appropriated	$167,500,000	$197,373,871	$241,485,482	$205,915,571
Other Appropriated	$29,500,000^	$41,791,585^	$47,488,051	$103,599,376
Federal Funds	$294,400,000	$374,021,174	$455,108,335	$487,850,574
TOTAL	$491,400,000	$613,186,630	$744,081,868	$797,365,521

^ Includes rebates

* *Includes rebates and Health Initiative funds*

** *Includes rebates, PFRA, Health Initiative funds, and Healthy Family Trust Fund*

Note: Appropriated totals and Expenditure totals may not equal, indicating a supplemental appropriation.

Source: Historical Pharmaceutical Expenditure Data, Department of Social Services, Division of Medical Services.

Missouri Medicaid beneficiaries who participate in an MC+ Managed Care plan receive their pharmacy benefit through the managed care plan. Typically the managed care plan will contract with a pharmacy benefit manager for the administration of the program. Federal law requires Medicaid managed care plans to provide the same benefit that the traditional fee-for-service Medicaid plan provides to beneficiaries, and managed care plans cannot impose cost sharing requirements on Medicaid enrollees that exceed those authorized by federal law. Managed care organizations participating in the Medicaid program use many of the same cost containment tools that the state has begun using in its fee-for-service pharmacy program, including step therapy, clinical edits, prior authorization and preferred drug lists. However, Medicaid managed care plans are not subject to the reimbursement rate and dispensing fee requirements that the state must pay to Medicaid fee-for-service pharmacies.

The Missouri Medicaid Pharmacy Program administers the pharmacy benefit for Medicaid fee-for-service beneficiaries. Medicaid beneficiaries who are enrolled in managed care receive

pharmacy benefits through the managed care plan. George Oestreich, director of the Pharmacy Program testified about the rising cost of the program. The average price per prescription has risen 9.6% from 2002 to 2003. The current reimbursement rate for pharmaceuticals is the lowest of the following four measures:

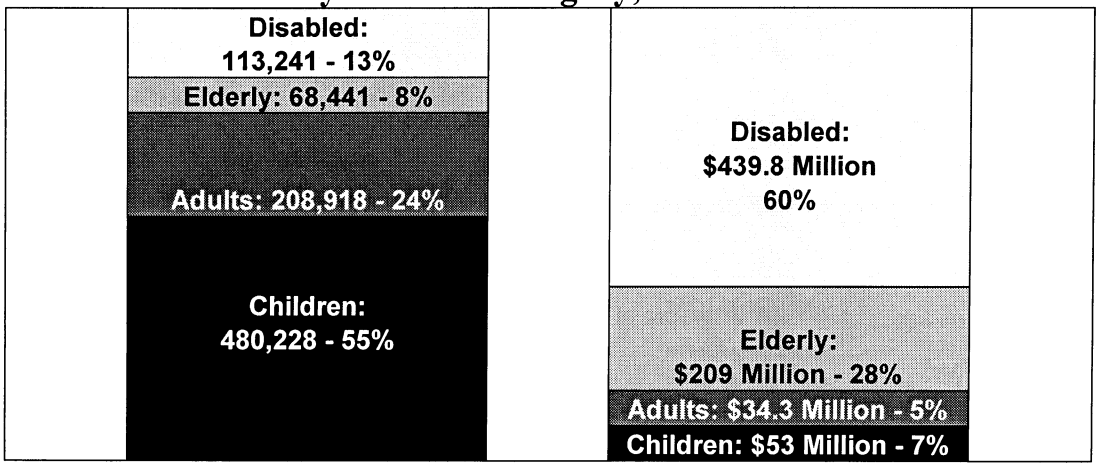
- Average Wholesale Price (AWP), less 10.43%;
- Wholesale Acquisition Cost (WAC), plus 10%;
- The Maximum Allowable Cost (MAC) or the Federal Upper Limit; or
- The usual and customary cost for the drug.

In addition to this rate, a dispensing fee of $4.09 is paid for each prescription filled, as well as an enhancement to the dispensing fee that is based on the Pharmacy Reimbursement Allowance that was enacted in 2002.

Overall, the major cost drivers for the pharmacy program include increases in utilization, the price of drugs, the number of recipients and their age, and recipient co-morbidities. The disabled and elderly beneficiary populations have greater costs than other beneficiary populations in the Medicaid program, and the disabled Medicaid beneficiary population is the group that is increasing most rapidly in Missouri. Within the disabled beneficiary population, pharmaceuticals for mental health needs are the number-one cost driver.

The chart below illustrates the relationship between the number of eligibles in each of the four general categories, and the pharmacy expenditures for that group. The numbers are a snapshot from fiscal year 2002, but the relationships today are similar. The chart shows that even though the disabled and elderly categories represent 21% of the Medicaid population, they consume almost 90% of Medicaid pharmacy budget dollars

Breakdown of Missouri Medicaid Pharmacy Dollars by General Category, Fiscal Year 2002



Note: The Missouri Pharmacy program only reports numbers for those covered by a fee-for-service plan. Since the disabled and elderly populations are currently not participating in managed care, these numbers may be slightly skewed. Source, Missouri Division of Medical Services

In response to increasing costs, the Missouri Medicaid Pharmacy Program has implemented various cost containment measures in recent years. These measures include:

- ✓ Implementing a Maximum Allowable Cost (MAC) list;
- ✓ Requiring Prior Authorization of all new drugs;
- ✓ Implementing the use of tools such as clinical edits, step therapies, and SmartPA;
- ✓ Encouraging the use of generics; and
- ✓ Limiting coverage for over-the-counter medications;

Maximum Allowable Cost list (MAC)

One way that Missouri's Medicaid program encourages the use of generic drugs is through the use of the Maximum Allowable Cost list (MAC). The MAC is determined by the Division of Medical Services and represents the maximum reimbursement rate for a product based on the generic drug. A MAC can be developed only for generic drugs that have been available for at least six months, and that have multiple sources. A multiple source drug is one that is marketed or sold by two or more manufacturers or labelers, or is sold by the same manufacturer under two different names.[57]

Since the use of the MAC price list began in 2001, the state has saved over $75 million, the majority of which was realized in the first 18 months of the program. Recent quarterly updates show an expected decline in savings. In the third quarter of fiscal year 2001, the savings was just short of $15 million, and the savings in each quarter of fiscal year 2003 was about $1 million.[58]

Clinical Edits, Step Therapies, and SmartPA

Clinical Edits, Step Therapies, and Prior Authorization are three related cost-containment measures used by the Medicaid Pharmacy Program. Clinical edits represent the lowest level of cost containment. They require the characteristics of the drug being prescribed to match the characteristics and diagnosis of the person who will receive the drug. For example, a clinical edit would automatically allow Medicaid to pay for a drug that treats a condition that only occurs in women when it is prescribed to a woman, but would not allow automatic payment if the same drug were prescribed for a man.

The second level is Step Therapy. Step Therapy tries to ensure that providers at least try prescribing lower cost but equally effective pharmaceuticals before prescribing similar but costlier drugs. Step therapies are used only within a single therapeutic class.

Prior Authorization is the most restrictive of these three cost containment measures, and it also underlies both the clinical edits and step therapies. The rising cost of prescription drugs has led 30 states to start prior authorization (PA) programs. PA controls the distribution of medications by requiring an authorization for the medication before the prescription is filled. State regulations require that all new drugs be subject to prior authorization requirements. New drugs are automatically placed on the prior authorization list until the Division of Medical services conducts a review to determine whether the prior authorization restriction should continue. The review must be conducted within 30 days of the Division receiving notice that the drug is available on the market. At the end of the review period, the prior authorization restriction may be removed, or the Division may continue prior authorization pending additional review by the

Missouri Drug Prior Authorization Committee and the Drug Use Review Board. The Committee and the Board must consider recommendations relating to continuing prior authorization, and may receive comment from the general public. If the Committee decides that the prior authorization requirement should continue, it must hold a public hearing and make a recommendation to the Division. Drugs that continue to be subject to the prior authorization requirement must be reviewed annually.[59]

Some PA programs have been criticized as adding an administrative burden and provider inconvenience that outweighs potential savings. In order to avoid this problem, Missouri contracted with Heritage Information Systems, Inc in the summer of 2002 to utilize their SmartPA system. SmartPA is an automated system that streamlines the process for all stakeholders including physicians, pharmacists, patients, and insurance companies. The full integration of the Smart PA system was completed by the summer of 2003, and by the end of 2003, it is projected that Heritage's SmartPA system could save the Missouri Medicaid program $35 million in drug expenditures.[60]

The SmartPA system analyzes each patient's drug and medical data in order to determine the drug's authorization status. After the prescription is presented to the pharmacist, the claim is submitted to the SmartPA system, which also automatically checks for insurance eligibility. SmartPA queries the administrative databases, prior drug claims, and prior medical claims, before determining if the screening criteria are met. If the prescription fits all the criteria the prescription is approved for payment and distribution. If the prescription fails the process, the provider is sent a message instructing them to call the help desk for approval.[61]

In a traditional PA system, the prescribing physician must place a phone call each time a drug requiring prior authorization is prescribed. When the physician contacts the traditional PA call center, they must relay the patient's claims data history and the call center enters the information into the system, then the authorization process begins. With SmartPA, roughly two-thirds of all prescriptions requiring prior authorization are approved through the automated system and do not require a phone call from the physician. This process reduces the administrative burden on the pharmacist, prescribing physician, patient, and call center.[62]

Smart PA achieves edit transparency without taking the control of treating the patient away from the physician. The actual savings realized by Missouri due to prior authorization with SmartPA was $13,700,750 through June 30, 2003. The projected savings for calendar year 2003 is $35,648,000, and the projected savings for fiscal year 2004 is $30 million.[63]

Preferred Drug List with Supplemental Rebates

In addition to the cost containment measures outlined above, the Division of Medical Services has recently begun to implement the use of a preferred drug list and supplemental rebates to further aid in containing costs of the Medicaid Pharmacy Program. The Division of Medical Services on October 31, 2003 issued the request for the preferred drug list. A preferred drug list is essentially a list of drugs that are designated as the preferred product in each drug class. In exchange for the preferred designation, the pharmaceutical company that manufactures the drug agrees to pay a supplemental rebate to the state, in addition to the rebates that are already

required by federal law. The product choice must be consistent with medical evidence and program cost. Officials from the Division of Medical Services project a savings to the state of $15 million per quarter in fiscal year 2004. This estimated saving is not agreed upon by all parties in the pharmaceutical industry. This estimate is based on the experiences of other states such as Florida and Michigan, who realized similar cost savings after the implementation of a preferred drug list. However, these states had not implemented other cost-containment measures when they implemented the list.

In addition to the upcoming implementation of the preferred drug list, the Division of Medical Services has several cost-containment regulatory issues pending. These issues include

- ❖ Regulatory changes in the pharmacy tax to reflect statutory changes from 2003;
- ❖ Designating Medicaid's role as payer of last resort for the pharmacy program;
- ❖ Requiring documentation of pharmaceutical counseling and services delivery;
- ❖ Requiring spend-down recipients to be limited to a 31 day supply of pharmaceuticals;
- ❖ Long-term care billing changes.

Consolidating Medicaid Drug Purchasing

This year, Arizona, Illinois, and Iowa made moves toward consolidating the purchasing of Medicaid drugs under a single agency. Some states, including Michigan, South Carolina, Vermont, and Wisconsin are preparing to implement aggregate purchasing alliances for Medicaid drugs.[64]

Drug Repository Program

Another form of Medicaid pharmacy cost containment is the possible development of the Drug Repository Program. This program would be regulated by the Department of Health and Senior Services allowing them the authority to adopt and promulgate rules regarding the program. Under the program, pharmacies that volunteer to participate would accept prescription drugs from any prescription drug manufacturer or health care facility and dispense them to residents of Missouri based on economic need. The prescription drugs received would be required to meet the following criteria:

- ✓ They must be contained in their original, sealed, and tamper-evident unit dose package; or
- ✓ They must be contained in an unopened, undisturbed multi or single unit dose package; and
- ✓ They must bear an expiration date less than six months from the date the prescription is donated.

Based on limited studies, the cost savings of a drug repository program is between 4% and 10% of the total costs of the medications dispensed. More than 90% of the wasted medication is due to discontinuation, death of a patient, hospitalization of a patient, or a change in medication. (46). In Missouri it is estimated the potential savings of this program is conservatively $6 million per year.

DISEASE AND CASE MANAGEMENT

Disease Management

Disease Management is defined as the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of problems relative to an illness or syndrome.[65] In Missouri, the disease management program is known as Disease State Management or DSM In essence, it arms the patient with the information they need in order to play an active role in controlling the rate at which their disease worsens, spreads, or develops complications.

The DSM team not only includes the patient but also requires active participation by the pharmacy and the physician. The team utilizes evidence based practice guidelines and empowerment strategies to provide the patient with the best information to prevent exacerbations and complications associated with their disease.

In Missouri, the DSM program was initiated in October of 2000 and started patient enrollment in May of 2003. The program is managed by George Oestreich, Director, DMS Pharmacy Program. The program includes the Medicaid Fee for Service (FFS) population who suffer from asthma, diabetes, chronic heart failure, or depression.

Patients targeted for the program include those FFS Medicaid enrollees who are on more than nine prescription medications, are not in the long-term care program, and have one of the four diseases listed above. Of the nearly 500,000 FFS enrollees, approximately 25,000 qualify to participate in the DSM program. Because of the newness of DSM, only 613 patients are currently enrolled. DSM projects to grow this participation level to 1,600 participants by June of 2004 and 2,500 participants by June of 2005.

Expenses associated with this program include administration and provider payment costs. It is projected that program administration costs will be $660,000 in fiscal year 2004 and $1,060,000 in fiscal year 2005. It is projected that provider payments for DSM will be $500,000 in fiscal year 2004 and $840,000 in fiscal year 2005. George Oestreich testified that these expenses include a $75 fee paid to participating pharmacists and physicians for the first visit by the patient, and $40 per visit for each of three subsequent visits.

The benefits of DSM are not yet measurable but officials from the Department of Social Services expect to have preliminary results published by February 2004. They anticipate short-term benefits including better control of care and reduced emergency room visits. Long-term benefits are expected to include limiting the advance of disease and controlling the outbreak of secondary diseases and side effects.

As of December 2002 more than 20 states were engaged in developing and implementing a Medicaid disease management program. Only a few of these states began DM implementation in the 1990s and have been able to measure results. In the 1990s Maryland developed the Diabetes Care Program as an adjunct to their existing PCCM program. Physicians and nurses who completed a five-hour continuing education course could qualify to receive a $20 monthly

care management fee per member served. Some state programs focused broadly on patient care management that encompasses all medical services for patients with specific diseases. States using this approach include Florida, North Carolina, Texas, and West Virginia. Other states, including Virginia and Mississippi, took a different approach focusing on managing pharmaceutical services. Pharmaceutical DM programs are less labor intensive and less costly than comprehensive DM programs, but may offer less potential savings and care improvements.

One strategy of DM programs focusing on pharmaceuticals is to allow pharmaceutical companies to provide grant support to fund DM programs. Florida and Washington have used an option that places their vendor at risk for savings in their DM service contracts. Savings guarantees have ranged from 2% to 6.5%.[66]

States that have conducted DM program evaluations as of December 2002 include Florida, Maryland, North Carolina, and Virginia. Florida has the largest and oldest Medicaid DM program in the country. Although Florida believes the program has improved the quality of care, expenditures have been found to offset program savings. In May of 2001, the Florida legislature criticized the DM program for not meeting savings goals. The legislature projected savings of $113 million over the years of 1998 to 2001, but the program was not close to that level of savings. In June of 2001 Florida contracted with Pfizer Health Solutions and Bristol-Meyers Squibb to operate a new DM program. Pfizer and Bristol-Meyers Squibb were granted placement on the Florida preferred drug list free of supplemental price rebates. The drug companies agreed to guarantee savings of a combined $49 million in two years under this agreement.

States that designed an in-house approach to DM, including Maryland, North Carolina, Virginia, and West Virginia, were able to record successes in reducing expenditures and improving quality of care. Some of Virginia's pilot program successes include an estimated $3 in savings per $1 spent and a 41% reduction in ER visits for treatment of Asthma. This pilot program was expensive to administer and Virginia soon moved to an outsourced model focusing on pharmaceutical care management.[67]

Case Management

Case Management is similar to DSM but has more intensive and inclusive interventions. Instead of using a disease as the main factor, case management focuses on patients that have extremely complicated healthcare issues. Case management aims to coordinate a patient's care across an episode or continuum of care focusing on attaining the correct services to create opportunities that enhance patient outcomes while controlling costs associated with care. The Department of Social Services anticipates enrolling the first case management patients in the first quarter of 2004. They project that 200 patients will be involved in fiscal year 2004, with a cost of $750,000. The Division of Medical Services, the Department of Health and Senior Services, the Department of Mental Health, and the Missouri Hospital Association have collaborated in the development of the Case Management program.

Care Coordination

Dr. John Lynch, Medical Director for Washington University Care Coordination testified about the University's care coordination program. The program's goal is to improve the health status of the top two to three percent of the population most in need who consume 30% of all healthcare resources. The program focuses on prospective coordination of care. Washington University began using this program in 1998 and in its first year of implementation the high-risk, high-cost population saw its hospitalization rate fall from 25% per month before care coordination to 7% per month after care coordination. They estimate that the significant cost savings realized through reduced hospitalizations yielded a 12:1 return on investment.

In April 2002, Washington University received funding from the Centers for Medicare and Medicaid Services as one of 15 sites chosen to run a care coordination or disease management demonstration project. Enrollment of participants, who are Medicare Part A and B beneficiaries, began in August 2002 and currently 1,500 participants are enrolled. The program has a goal of 2,000 participants, and will be evaluated by CMS over the next four years.

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are private not-for-profit or public entities that provide comprehensive primary health care, maternity and pre-natal care, preventative care for infants, children, and adults, some emergency care, and pharmaceutical services for recipients of all ages. They are part of a federal grant program that is authorized by section 330 of the Public Health Services Act and reauthorized under the Health Centers Consolidation Act of 1996. They include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers.

FQHCs serve approximately 93 million medically under-served Americans, including many uninsured individuals.[68] The centers are supported financially by federal grants, Medicaid, Medicare, private insurance payments, patient payments, and state and local contributions. According to the National Association of Community Health Centers, state and local sources provide half of the funds for FQHCs, through Medicaid (35%), state and local funds (12%), and the children's health insurance program (3%). Additional funding comes from federal grants (26%), private insurance (11%), Medicare (6%), and patient's payments (7%).[69]

FQHCs provide community-based and consumer driven services. Federal law requires at least 51% of an FQHC's board of directors to be comprised of individuals who are patients at the center. They are located in rural or urban communities that experience barriers to receiving health care, and must provide care to all residents of their service area. Charges for care are on a sliding fee scheduled, based on the individual's ability to pay. FQHCs must maintain on-going quality assurance programs, and are required to submit an annual independent audit and regular financial reports.

In exchange for providing care to an under-served and uninsured population, FQHCs are eligible for several benefits under federal law. These benefits include:

- Access to federal grants for expansion to support the cost of uncompensated primary and preventive health care;
- Access to federal grants for the costs of planning and developing a network or other plan for the provision of health services;
- Federal loan guarantees for the costs of developing and operating managed care networks or plans which are majority owned or controlled by the health center;
- Grant support and grant guarantees for capital improvements;
- Access to Federal Tort Claims Act coverage for the health center, its professional staff and certain contractors, in lieu of purchasing malpractice insurance;
- Favorable drug pricing (known as "340b pricing") to purchase prescription drugs for health center patents at substantially discounted prices for distribution either directly by a health center pharmacy or by contract with a retail pharmacy;
- Access to reimbursement under the prospective payment system or other state-approved alternative payment methodology for Medicaid services, and cost-based reimbursement for services provided under Medicare;
- Ability to have the state Medicaid agency station Medicaid eligibility workers on the FQHC site;

- Ability to waive deductible for services rendered to Medicare beneficiaries, with reimbursement by Medicare for "first dollar" of such services;
- Safe harbor under federal anti-kickback statute for waiver of co-payments for patients who are below 200% of the federal poverty guideline. Such patients are entitled to a discount based on the health center's application of its discount schedule;
- Access to providers through the National Health Service Corps if the service area is designated a Health Professional shortage area;
- Access to the Federal Vaccine for Children program which distributes vaccinations at no charge to be provided to uninsured children; and
- Access to the Chronic Care Model, a disease management/care model that is population-based and relies on knowing which patients have an illness, assuring that they receive evidence-based care, and actively aiding them to participate in their own care.[70]

President Bush announced an initiative in 2001 to increase the number of health centers and improve access to primary health care. The Health Center Initiative is a five-year, $2.2 billion plan to build 1,200 new health centers, with the goal of serving 6 million new patients. The initiative highlights FQHCs as a method of delivering cost-effective health care to under-served and uninsured individuals. FQHCs help improve infant mortality rates, encourage prenatal care, reduce low birth weights, control chronic diseases and disability, and decrease the use of emergency rooms for non-emergency purposes.[71]

According to the Missouri Primary Care Association, Missouri FQHCs served 77,000 Medicaid patients last year, at an estimated $663 savings per Medicaid patient. It is estimated that there were 231,624 unnecessary emergency room visits (10% of all ER visits at $650/visit) last year in Missouri. Unnecessary emergency room visits are more likely to occur with the uninsured and the Medicaid recipients who do not have access to comprehensive primary health and dental care. Increased usage of FQHCs and reduced utilization in emergency room care at Missouri hospitals could save $150.6 million annually.

THIRD PARTY RECOVERY

Federal law requires Medicaid to be the payer of last resort. When available, Medicaid expenditures must be offset by third party resources. A third party resource is "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan."[72] Third party resources include private insurance, medical support by non-custodial parents, accident and automobile insurance, court judgments or settlements in trauma related cases, homeowner's insurance, malpractice insurance, product liability insurance, trust accounts, workers compensation, probate recoveries, long-term care insurance, and Medicare. Federal law also mandates states to do cost recovery for pregnant women, children, and other eligibility groups. Estate recovery is done upon the death of a surviving spouse. Medicaid also pursues casualty recovery should there be an accident or casualty insurance payment.

In fiscal year 2002, Missouri's Third Party Liability unit collected a total of $31 million and in fiscal year 2003, they collected a total of $28 million. In fiscal year 2003, there were 41 employees working on Third Party Recovery efforts for the Division of Medical Services. The actual expenditure for fiscal year 2003 for personal service and equipment and expenses was $1,947,352.

Type of Recovery	FY02	FY03
Casualty	$5,118,658	$5,253,763
Estates	$7,294,996	$5,786,100
Health	$476,304	$511,726
TPL	$83,701	$25,475
Medicare	$3,958,751	$5,000,921
Contractor	$14,405,735	$11,727,177
TOTAL	**$31,338,145**	**$28,305,162**

Source: Missouri Department of Social Services, Division of Medical Services presentation by Christine Rackers to the Interim Committee on Medicaid Cost and Containment, October 10, 2003.

On average, each worker in the unit collects $400,000 each year. The unit is short-staffed and the decline in collections may partially be a result of a lack of staff. Christine Rackers testified that the unit might be missing as much as $4 million per year because of a lack of staff. With all recoveries, the federal government gets its share back, and the states share goes back into the Medicaid program. With dual eligibles, Medicare is billed first, but Medicaid pays co-payments and some premiums.

In addition to the staff of the Third Party Recovery unit in the Division of Medical Services, the Division contracts with Health Management Systems, Inc for third party fund recovery. Health Management Systems identifies and recovers funds from third parties who were responsible for coverage that was actually paid by the state Medicaid program. Health Management Systems is the nation's largest provider of third party recovery services, and has recovered over $2 billion for 30 states. Since 1998, Health Management Systems has recovered over $66 million for Missouri's Medicaid program. Health Management Systems has recently been awarded a third party recovery contract to provide additional services for the Department of Social Services, as well as services for the Department of Mental Health. [73]

FEDERAL INITIATIVE – MEDICARE PRESCRIPTION DRUG COVERAGE IMPACTS ON MEDICAID

In December 2003 President Bush signed into law a Medicare prescription drug bill to increase prescription drug coverage to seniors. It is the first major overhaul of the Medicare entitlement program since its inception in 1965.

Although the impacts this legislation will have on Missouri's Medicaid program is yet unknown, the following outlines some information from the Centers for Medicare and Medicaid Services.[74]

- The bipartisan agreement provides all of the 888,126 beneficiaries in Missouri with access to a Medicare prescription drug benefit beginning in January 2006.
- Within six months of the bill being signed by President Bush, Missouri residents will be eligible for Medicare-approved prescription drug discount cards. These discount cards will provide savings between 10% and 25% off the retail price of most drugs.
- Beneficiaries with incomes less than $12,123 for a single and $16,362 for a couple who lack prescription drug coverage will get up to $600 in annual assistance to help with prescription purchases. This adds up to a $208,343,220 in additional assistance for 173,619 Missouri residence in 2004 and 2005.
- Beginning in 2006, all 888,126 Missouri Medicare beneficiaries will be eligible to get prescription drug coverage. In exchange for a monthly premium of about $35, seniors who are now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half.
- 269,1421 Missouri beneficiaries with lower incomes will pay no premium for their prescription drug coverage but will be responsible for a nominal co-payment (no more than $2 for generic drugs or $5 for brand name drugs.)
- Medicare, instead of Medicaid, will assume the prescription drug costs of 144,468 Missouri beneficiaries who are eligible for both Medicare and Medicaid. This will save Missouri $658 million over eight years.

According to the Center for Health Policy at the University of Missouri-Columbia, Medicare will begin covering the costs of prescription drugs for dual eligibles in 2006. However, states will also be required to pay a "federal claw-back rate" which is a portion of the revenues for the dual eligibles. In 2006, Medicaid must pay 90% of the cost of the Medicare prescription drug coverage for dual eligibles back to the federal government. This percentage will be reduced annually until it is capped at 75% of drug costs for all years after 2014. In 2006, Missouri would realize a $166 million benefit, but after paying 90% of the cost back to the federal government, the state would keep only $16 million. Because of the high claw-back percentages in the initial years of the program, Missouri will likely not see significant savings, however savings should increase as the claw-back percentage decreases. Administrative costs for the new program are also unknown and may significantly reduce any cost savings to the state. [75]

RECOMMENDATIONS

Medical Assistance for Families

Federal law requires states to cover Medical Assistance for Families recipients with incomes up to the state's AFDC income level as of July 16, 1996. In Missouri, this is equal to between 18 and 23 % of the federal poverty level. Missouri currently covers individuals with incomes up to 77% of the federal poverty level at its option. Missouri also does not impose asset limits on recipients of Medical Assistance for Families. However, Federal law allows states the option of imposing an asset test as long as it is no more restrictive than the state's AFDC level as of July 16, 1996, which was less than or equal to $1,000 in countable assets. The committee recommends reviewing the impacts of adding an asset limit of $1,000 for MAF enrollees.

MC+ for Pregnant Women and Newborns

Missouri MC+ for Pregnant Women and Newborns provides Medicaid coverage for pregnant women and their newborn children who have family incomes up to 185% of the federal poverty level with no asset limits. The federal requirement for this eligibility group is up to 133% of the federal poverty level. Federal law requires an added asset limit cannot be more restrictive than the July 1996 limit for AFDC of $1,000. Exempt assets include the home and 40 acres surrounding it, $1,500 equity in one vehicle, one burial lot per family member, property used in the course of business or employment, and household furnishings. The committee recommends reviewing the impacts of adding an asset limit of $1,000 for pregnant women.

Managed Care

Missouri's Medicaid Managed Care program is a medical assistance program for low-income families, pregnant women, children, and uninsured parents, who are required to enroll in their choice of seven managed care plans. MC+ Managed Care started in Missouri in 1995. Missouri is currently one of 48 states that have a Medicaid Managed Care program. Currently only 37 counties, all of which fall along the I-70 corridor, are participating in the MC+ Managed Care program. It is estimated that the state of Missouri has realized a $200 million savings under the current MC+ Managed Care program. According to the Kaiser Foundation, 36 states enroll some people with disabilities into managed care, Missouri is not one of those states. The committee recommends the state of Missouri further investigate the possibilities of expanding the current Managed Care system to include the elderly, blind, and disabled populations into the area of the state already participating in Medicaid managed care.

Long Term Care

Federal law requires Medicaid recipients seeking either home and community based services or admission to a nursing facility to be evaluated to determine the individual's level of care (LOC). If the LOC is measured at or above a score of 18, the individual is eligible for both home and community based services and nursing home care. The committee recommends that LOC be reviewed to assure a score of 18 is appropriate and the characteristics to earn a point are sensible.

Pharmaceuticals

SmartPA program – Traditional prior authorization programs have been criticized as increasing administrative burdens and creating provider inconveniences that outweigh potential savings. In order to avoid this problem, Missouri contracted with Heritage Information Systems, Inc to utilize their SmartPA system. SmartPA is an automated system that streamlines the process for all stakeholders including physicians, pharmacists, patients, and insurance companies. By the end of 2003, it is projected that Heritage's SmartPA system could save the Missouri Medicaid program $35 million in drug expenditures. The committee encourages Missouri participation in the SmartPA program and the effort to expand the list of drugs covered.

Drug Repository program – This program invites participating pharmacies to receive acceptable prescription drugs from any prescription drug manufacturer or health care facility and dispense them to residents of Missouri based on economic need. Based on limited studies, the cost savings of a drug repository program is between 4% and 10% of the total costs of the medications dispensed. The committee recommends the state of Missouri move forward in implementing the Drug Repository program.

Federal Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are not-for-profit or public entities that provide primary health care, maternity and pre-natal care, preventative care for infants, children, and adults, some emergency care, and pharmaceutical services for recipients of all ages. Last year Missouri FQHCs served 77,000 Medicaid patients at an estimated savings of $663 per patient. It was also estimated that FQHCs prevented 231,624 unnecessary emergency room visits ($650/visit). This reduction in emergency room visits could save $150.6 million annually. The committee encourages the expansion of FQHC facilities.

Third Party Recovery

In addition to the staff of the Third Party Recovery unit in the Division of Medical Services, the Division contracts with Health Management Systems, Inc for third party commercial insurance fund recovery. Health Management Systems identifies and recovers funds from third parties who were responsible for coverage that was actually paid by the state Medicaid program. Health Management Systems is the nation's largest provider of third party recovery services, and has recovered over $2 billion for 30 states. Since 1998, Health Management Systems has recovered over $66 million for Missouri's Medicaid program. Health Management Systems has recently been awarded a third party recovery contract to provide additional services for the Department of Social Services, as well as services for the Department of Mental Health.

There are six areas included in third party recovery. They are: Commercial Insurance Recovery, Medicare Recovery, Causality and Tort Recovery, State Probate Recovery, Health Insurance Premium Payment (HIPP), and Medicare Buy-In. HMS could contract all third party recovery efforts with the exception of HIPP and Medicare Buy-In under the existing contract. The committee recommends the state of Missouri include the additional three third party recovery efforts to HMS under the existing contract.

Optional Services

Missouri Medicaid provides coverage for several optional services including adult dental and optical care, and rehabilitation and physical therapy services. In total, optional services cost the state $1,584,413,849 each year. The committee recommends the review of optional services for possible program reduction.

Estate Planning Relating to Qualifying for Long Term Care Coverage

Medicaid is essentially the only publicly funded source of long term care coverage. In order to qualify for this coverage individuals must meet financial eligibility guidelines, including income and asset limits. In attempting to qualify for Medicaid long term care coverage, individuals use multiple strategies to legally shelter assets. The amount of assets sheltered sometimes number in the hundreds of thousands of dollars. These strategies include estate planning and the purchasing of annuities. Results from a survey conducted by the American Public Human Services Association and published in October 2003 found that most states feel annuities are a major source of asset-sheltering activity. The committee recommends a thorough review of federal and state laws, regulations, and policies surrounding the long term care qualification process to ensure only legal and fair asset-sheltering activities are used to qualify for Medicaid coverage.

Eligibility Determination

In Missouri, the Family Support Division of the Department of Social Services is responsible for determining eligibility for Medicaid. The process requires an applicant to fill out forms which request information including income, resources, household information, age of the applicant and household members, and access to health insurance. A caseworker also conducts an interview to discuss the information contained in the application. On questions such as income, resources, and access to health insurance an applicant's word is accepted as fact. The committee recommends reviewing state resources to determine if information exists that can be utilized to verify applicant statements. The committee also recommends considering that additional documentation be provided at the time of application in order to be considered for Medicaid coverage. This may include mandatory disclosure of pay stubs.

APPENDIX A – WITNESS LIST

September 9, 2003 – Jefferson City, Missouri

Christine Rackers, Division of Medical Services
Denise Cross, Family Support Division
George Oestreich, Medicaid Pharmacy Program

October 10, 2003 – Jefferson City, Missouri

Donna Checkett, Missouri Care Health Plan
Chris Christea, Community Care Plus
Marcia Albridge, Health Care USA
Christine Rackers, Division of Medical Services
Denise Cross, Family Support Division
Esra Murray, Family Support Division
Marie Fann, Family Support Division
Roger Rome, Family Support Division
Chris Reeter, Family Support Division
Larry Rohrbach, Missouri Association of Homes for the Aging
Cheryl Fitch, Oxford Health Care
Karen Thomas, Oxford Health Care
Dwight Fine, Missouri Hospital Association
Daniel Landon, Missouri Hospital Association

October 27, 2003 – Program of All-Inclusive Care for the Elderly - St. Louis, Missouri

Deno Fabbre, Alexian Brothers PACE
Dr. Richard Schamp, Alexian Brothers PACE
Christopher Ward, PhRMA
Eric Haider, Crestview Homes, Inc.
George Oestreich, Medicaid Pharmacy Program
Dr. John Lynch, Washington University Care Coordination
Jacqueline Lukitsch, NAMI St. Louis
Glenn Koenen, Circle of Concern and St. Louis Metro Food Pantry Association
Marge Parrish, Mental Health Association of Greater St. Louis

November 17, 2003 – Family Health Center - Columbia, Missouri

Denise Cross, Family Support Division
George Oestreich, Medicaid Pharmacy Program
Chris Johnson, Heritage Information Systems
Carol Curtis, PhRMA
Margie Mueller, Division of Medical Services
Becky Rucker, Division of Medical Services
David Morgan, Department of Health and Senior Services
Denise Clemonds, Missouri Association of Homes for the Aging
Larry Rohrbach, Missouri Association of Homes for the Aging
Earl Carlson, Missouri Health Care Association
Tom Crawford, Missouri Health Care Association
Kirsten Dunham, Paraquad

APPENDIX B – SUPPORTING DOCUMENTATION

Supporting Documents include:

- Level of Care Scores
- MC+ Managed Care Covered Counties
- Income Guidelines for MC+ for Kids, Medical Assistance for Families, and Temporary Assistance
- Eligibility Requirements and Covered Services for Medicaid Family Health Care Programs
- Income and Asset Guidelines for the Elderly, Blind, Disabled, and those in need of treatment for Breast and Cervical Cancer
- Eligibility Requirements and Covered Services for the Elderly, Blind, Disabled, and those in need of treatment for Breast and Cervical Cancer
- Top 25 Medications by dollars for Fiscal Year 2003
- Other States' Cost Containment Activities – Benefits and Eligibility Fiscal Year 2003 and Fiscal Year 2004
- Other States' Cost Containment Activities – Pharmacy Fiscal Year 2003 and Fiscal Year 2004
- National Nursing Home Reimbursement Rates
- Missouri Medicaid Enrollees 1993 – 2003
- Missouri Medicaid Expenditures Fiscal Year 2003
- 2003 Annual Federal Poverty Income Guidelines
- Medicaid Covered Services State by State

Level of Care Scores
Evaluation Guidelines
Source: Missouri Department of Health and Senior Services

POLICY:

Level of Care (LOC) scores are assessed and recorded on the DA-2 or DA-2b for all clients opened in the LTACS system. Determination of level of care is an eligibility factor for authorization of services under the plan of care (service plan). LOC scores shall be based on the documentation of assistance required and complexity of the care. This information is obtained during the assessment process.

PROCEDURE:

The Worker shall assign points based on information obtained during the interview process. The Worker shall document all information necessary to substantiate LOC scores. The following information is intended to guide the decision making process associated with LOC scores. The summary of circumstances and scores is a sample and in no way is representative of all situations for which scores may be assigned.

- Unless otherwise stated, licensed personnel are limited to LPN, RN, or Physician and professional personnel is limited to RN or Physician.

I. ***Monitoring:*** Document information regarding the frequency and level of monitoring being received. Documentation shall include all current medical supports (health care providers and physicians), health problems/condition (stable vs. unstable or deteriorating) being monitored, and related monitoring procedure. Prior to assigning points for monitoring, the Worker must know that physician orders exist, the specific conditions being monitored and the procedure used to monitor that condition by verifying this information with the

Points are assigned for monitoring of a specific physical or mental condition by (or ordered by) a physician.

Points vary (0-9) according to the stability and degree of monitoring of the client's condition.

Frequency - Assigning points for monitoring requires documentation of information regarding physician (ordered) monitoring contacts which occur at least once per month.

Procedure - Assigning points for monitoring will require documentation regarding the specific measures taken during the monitoring visits. [Typical procedures which qualify for monitoring include, but not limited to blood pressure; intake and output; weight; temperature; pulse and respiration; and lab tests such as fasting blood sugar, urinalysis, digoxin level or protime].

Condition - Assigning 6 or 9 points for monitoring requires documentation sufficient to establish the instability or deteriorating condition for which monitoring is being conducted. Unless otherwise noted, it will be assumed monitoring is for a STABLE condition.

0 points	**3 points**	**6 points**	**9 points**
None or routine monitoring. No physician's orders exist. Nurse visits: authorized by DA; delivered PRN; or to check vitals as a preventive measure. Daily or PRN monitoring by neighbors or friends.	Minimal monitoring. Physician visits no less than ONCE per month to monitor a specific mental or physical condition. Nurse visits: to check a particular stable health problem or condition at least ONCE per month. Monitoring is for a STABLE CONDITION.	Moderate monitoring. Same conditions as 3 points, except: Monitoring is for an **UNSTABLE** CONDITION as verified through the physician or other licensed personnel.	Maximum monitoring. Same conditions as 3 and 6 points except: Monitoring is for an **UNSTABLE** CONDITION as verified through the physician or other licensed personnel that requires **INTENSIVE** Continuous monitoring by licensed personnel or trained caregiver, which may include family.

II. ***Medications:*** Include all medications taken by the client (or which the client SHOULD be taking), and the level of human assistance or supervision required to properly administer medications.

Medications are generally anything which affects the entire body, whether taken orally, injected (e.g., insulin, B-12 shots), or inserted or dropped into the eyes, ears, nose, vagina, or rectum. Examples of locally applied medications which are pointable include nitrobid salve rubbed over the heart, and nitropads or patches, in-halers, and insulin injections all of which are absorbed into the blood stream affecting the whole body.

Note: Medications which are applied to "localized area or condition" are considered and pointed as a treatment (see below).

Points are assigned for physician ordered medications (prescription or over-the-counter), which the client SHOULD be taking.

Points vary (0-9) according to the physician's orders and the amount of assistance NEEDED to administer medications properly.

0 points	**3 points**	**6 points**	**9 points**
No medications have been prescribed by a physician. Irregular use of prescribed PRN medication.	Client has prescription medications, or physician ordered over-the-counter drugs. Client SHOULD be taking medications. Prescribed regular use of PRN medication. NO assistance needed.	NEEDS to be supervised either by licensed personnel, certified medical technician, family, caregiver, etc. Daily or weekly med set-ups (or insulin draws).	Total assistance is needed. Complex drug regime (i.e. multiple drug prescriptions with various dosages). Drug regime requiring professional observation and assessment, [*this will rarely occur in an RCF*].

III. ***Treatments:*** Include information regarding any physician ordered **medical procedure**, intended to treat a specific medical condition. The Worker must determine the frequency of the treatment, problems or conditions associated with the treatment, what is being done, and by whom.

Document complicated treatments which are extensive in nature or of a critical or crisis nature. Physician's orders will assist in determining the type of treatment and the existence of orders. Treatments which qualify for points under any one area represent the maximum points assignable; the scores are not cumulative in nature.

Points are assigned for any systematic course of medical procedures for a specific condition, ordered by a physician.

Points vary (0-9) in according to type and frequency of treatment and associated problems or complications.

Note: Level of care points relating to ostomies or catheters may be assigned under this section, and documentation should include problems with their care, whether they are new are old. Although documentation may be more appropriately recorded under "toileting", care should be taken that points are not duplicated under Personal Care (see below).

Treatments are usually prescribed for a certain localized condition or problem.

0 points	3 points	6 points	9 points
No treatments have been ordered.	Minimal physician ordered treatments. Non-routine, preventative measures (e.g. douches; enemas; whirlpool baths; hot wax for arthritis; suppositories for constipation; most medications rubbed on the skin; Rx heating pads; or ice bags). Simple dressing (applied to protect an injured area, cover applied medication, or absorb drainage). External catheter or ostomy causing no problems. PRN oxygen, not needed daily.	Moderate physician ordered treatments, requiring daily attention by licensed personnel, even if done by family, caregiver, etc. Cupping to break up phlegm. Caring for skin disorders (stasis or decubitus ulcers) requiring daily dressings (routine, non-critical or non-crisis in nature). Indwelling catheter (or an external catheter or ostomy causing problems). Oral suctioning Stabilized outpatient dialysis (even if not daily). Foot soaks (on a daily or higher frequency for a specific condition). Daily breathing treatments (i.e., CPAP, maxi-mist, nebulizer, PRN oxygen needed daily).	Maximum physician ordered treatments, requiring direct supervision by a licensed personnel , even if done by family, caregiver, etc. Dressing of a deep draining lesion (more than 1 X day). Caring for extensive skin disorders (advanced decubiti or necrotic lesions). Endotracheal suctioning Chemotherapy (including intravenous and/or oral medications), radiation, and unstable dialysis. Continuous oxygen New or unregulated ostomy care. Maintenance of suprapubic catheter.

IV. ***Restorative:*** Specialized services provided to help client obtain and/or maintain, their optimal functioning potential. The client must have an individualized training/teaching program with written goals and progress towards those goals documented, which may include but are not limited to services outlined in Individualized Treatment or Habilitation Plans (ITP/IHP). The Worker will include information regarding the programs designed to train/teach the client, family, caregiver, etc. to do specific activities. Documentation must be sufficient to ascertain the goal of the **training** program (maintenance or restorative), frequency, and who performs the training activities.

Restorative services include, but are not limited to: teaching passive range of motion; bowel or bladder training program; remotivational therapy; self administration of medicine; patient/family programs; teaching/coaching in daily living skills including cooking, budgeting, paying bills, personal grooming, and self-directing their own care. Restorative services have a goal to maintain the current level of functioning, or restore the client to a higher level of functioning. The goal of the program is determined by the client and the agency providing the specialized services.

Points are assigned for training programs which are goal oriented toward maintaining the current level OR restoring to a higher level of functioning.

Points vary (0-9) according to the goal of the program (maintaining vs. restoring) and the frequency with which training activities are provided.

0 points	**3 points**	**6 points**	**9 points**
No restorative services are being received.	Minimal training/teaching activities. Goal is to **maintain** current functioning level, (e.g. teaching independent living skills, such as Individualized Treatment/ Habilitation Plans (ITP, IHP).	Moderate training/teaching activities. Goal is to help client **achieve** a higher level of functioning, (e.g. teaching a stroke patient to use adaptive eating devices; a diabetic client to fill syringes and give injections).	Intensive training/teaching activities designed to **restore client to a higher level** of functioning. (Generally ordered after an acute medical episode) Requires professional (licensed nurse or physician, not family member) supervision.

V. ***Rehabilitative:*** Document information regarding any therapy services designed to restore a former or normal state of functioning through physician ordered therapeutic services. Therapy services must be provided by a qualified therapist or under the supervision of a therapist. Rehabilitative services are: Physical Therapy; Occupational Therapy; Speech Therapy; and Audiology. Physician orders *may* be verified through the physician, home health agencies, and/or caregivers. If rehabilitative services have been ordered, points may still be assigned if the client is not receiving them.

Points are assigned for physician ordered therapeutic services provided by (or under the supervision of) a qualified therapist to restore a former or normal state of functioning.

Points vary (0-9) solely on the frequency of the NEED for services (even if the client is not receiving the services).

0 points	**3 points**	**6 points**	**9 points**
No physician ordered therapies.	Therapy is ordered 1 X weekly.	Therapy is ordered 2-3 X weekly.	Therapy is ordered 4 X weekly or more.

VI. ***Personal Care:*** Information needed for personal care determination is based on the highest of two components and their scores: *Grooming / Bathing* and *Toileting* (see Policy 1602.22). Documentation shall be included regarding the NEED for human assistance for grooming, bathing and/or incontinence.

Information must be included which documents the amount and frequency of human assistance required with grooming, bathing, problems with catheters or ostomies, who assists, and how often assistance is provided.

Note: Points should not be assigned here for catheters and / or ostomies. These are pointable as Treatments.

Points are assigned based on documented NEED for human assistance with grooming, bathing and/or problems associated with toileting.

Points vary (0-9) based on the amount and frequency of human assistance required (regardless of the assistance available to the client), and/or degree of incontinence.

Grooming and Bathing: dressing, bathing; shaving, dental, mouth, hair, and nail care.

0 points	3 points	6 points	9 points
Client refuses to bathe - but is ABLE. Client is able, but prefers to go to the beauty shop for hair care.	Occasional or minimal assistance required. Less than daily (e.g. help in/out of the tub, someone present, reminders/ encouragement). Client goes to the beauty shop as needs assistance with hair care. Client can no longer do nail care, requires periodic assistance.	Moderate human assistance required. Daily assistance with grooming. Substantial assistance with bathing required. Someone must be present to assist constantly with grooming and bathing needs.	ALL grooming and bathing must be performed by another.

Toileting: urinary incontinence, special equipment (raised seat; grab bar; urinal; commode; pads; diapers, etc.)

0 points	3 points	6 points	9 points
No assistance or special equipment is needed.	Minimal human assistance or special equipment is required. Infrequent incontinence.	Moderate human assistance in addition to special equipment is necessary. Frequent incontinence.	Maximum human assistance, total assistance with personal care required. Continuous incontinence.

VII. ***Dietary:*** Include information regarding any problems the client has associated with eating. Also note any physician prescribed calculated diets (including the condition for which prescribed). Documentation shall include problems with cooking, swallowing, chewing, vomiting, choking, cutting food, remembering to eat, assistive devices or special equipment.

Documentation shall include the amount of human assistance required to eat, including supervision to eat, cutting food, opening cartons, tube feeding, or meal preparation. The need for assistance may include problems associated with physical limitations, knowledge (doesn't know how to cook), or mental impairments (depression or confusion) which limit the client's ability to participate in the preparation and consumption of the meal.

Points are assigned based on the ability of the client to eat, prepare meals or the type of physician orders for calculated diet (based on a specific physical impairment). Points assigned for assistance shall be based on NEED, whether or not the assistance is available.

Points vary (0-9) according to the amount of human assistance required, type of special diet and the stability of the physical condition.

Physician orders for special diets shall include specific amounts to increase substances (such as protein, fiber, etc.) and involves weighing, measuring, calculating and/or severe restrictions (such as calories or fats).

0 points	**3 points**	**6 points**	**9 points**
No assistance required to eat. Prepares meals independently. No physician ordered diet. Meals eaten at a nutrition site or prepared by a facility which the client could have prepared. Minor modification: low fat; low sugar; low cholesterol; or low sodium. Mechanical alterations (including soft drinks or liquid supplements).	Minimum assistance required to eat (e.g. light supervision or encouragement, cutting, opening or pouring). Needs 50% or more of meals prepared by another (includes home delivered meals). Physician ordered **calculated** diet, prescribed for a specific condition.	Someone must be present at all times to supervise or to actually feed the client. All meals must be prepared by another. Physician ordered diet (as for 3 points, except) for an UNSTABLE condition.	Maximum human assistance required for dietary needs. Client is unable to participate in eating. Client requires tube feeding. Parenteral fluids (I.V.) required (Not generally appropriate for RCF residents).

VIII. ***Mobility:*** Include information regarding the cause and any limitations the client has with ambulating. Any assistive device which the client uses regularly (cane, quad-cane, crutches, walker, wheelchair, braces or prosthesis) should be noted, and the required human assistance associated with such devices.

Points are assigned based on the ability of the client to move from place to place.

Points vary (0-9) according to the amount of human assistance NEEDED to ambulate.

No points are assigned for clients who are generally capable of leaving their home for routine or typical activities (shopping, doctor, church, etc.) or for assistive devices - unless human assistance is required.

0 points	**3 points**	**6 points**	**9 points**
The client may use assistive devices, but is consistently capable of negotiating without human assistance.	Needs periodic human assistance without which the client could not get around (such as help on stairs). Client in wheelchair needing help in and out of chair.	Cannot ambulate safely without DIRECT human assistance. Someone must be present in order to ambulate. (Generally not appropriate in RCF setting).	Totally dependent on other persons to move. Persons who need turning or positioning and are generally passive. (Not appropriate in RCF setting).

IX. ***Behavior and Mental Condition:*** Information should be recorded which includes problems the client has with orientation, memory recall, and judgment. Documentation shall include a combination of specific questions, general observations and conversation which assist the Worker in evaluating the client's positive and negative involvement in the world.

Information should include functioning problems associated with depression, mood swings, disruptive or obstinate behavior, isolation, sleep problems, or recent losses. Documentation of diagnosed developmental disabilities, mental retardation or mental illness shall also be included.

Points are assigned according to the client's condition regarding orientation, memory, and judgment.

Points vary (0-9) based on the type and amount of assistance NEEDED (whether or not the assistance is received) by the client due to behavior or mental problems.

0 points	**3 points**	**6 points**	**9 points**
Client is well oriented and requires little or no assistance from others.	Minimum assistance needed: Supervision due to some memory lapse. Assistance required due to occasional forgetfulness. Generally relates well to others (positive or neutral). Client has/needs a payee or a conservator due to behavior or mental impairments.	Moderate assistance required due to: disorientation; mental or developmental disabilities; uncooperative behavior. Client has/needs a guardian.	Maximum assistance required due to: confusion; incompetence; hyperactivity; hostility; severe depression; suicidal tendency; hallucinations; delusions; bizarre behavior. Verbally or physically combative. Incapable of self-direction. Danger to self or others. Comatose/aphasic

MC+ Managed Care – Covered Counties

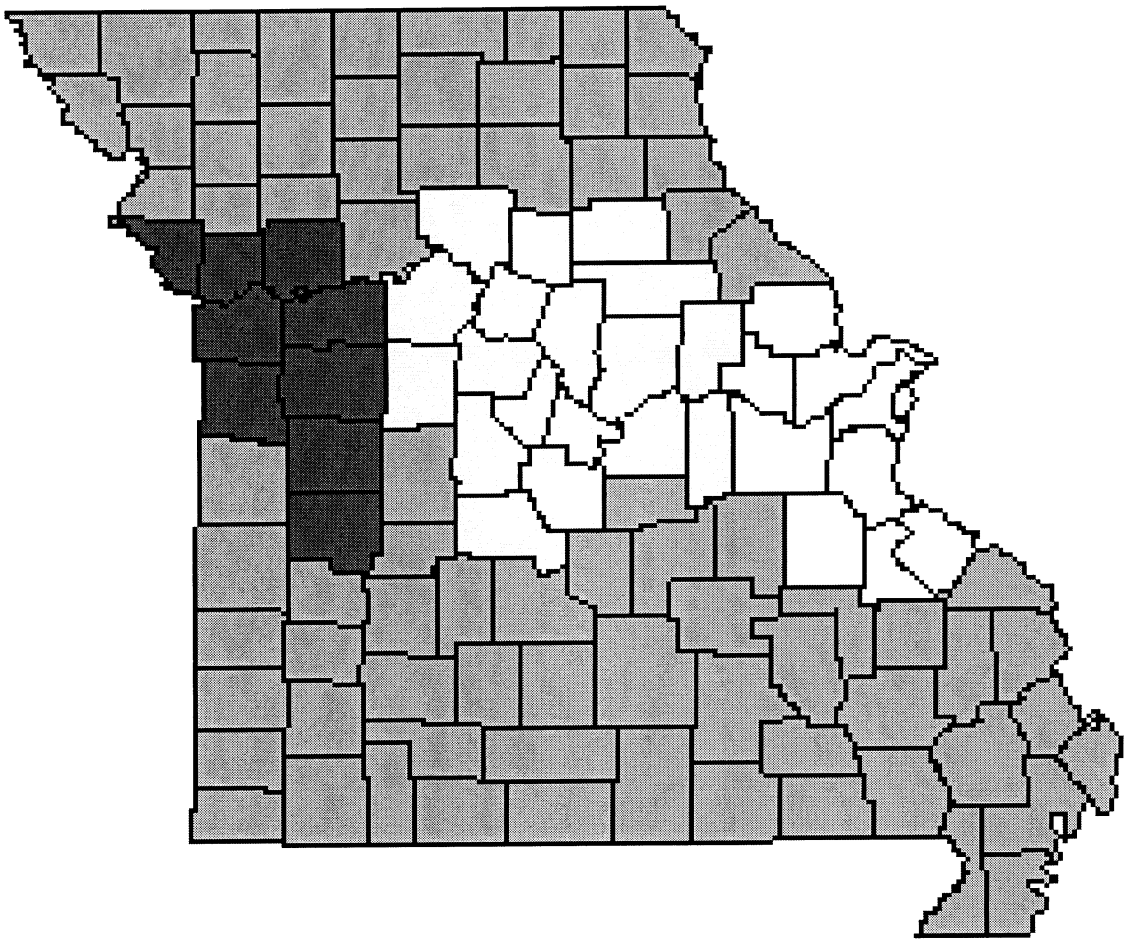
Source: Missouri Department of Social Services, Family Support Division
Missouri Care Health Plan

431,715 Missouri MC+ Managed Care Members, as of September 2003.

Western Region (134,640 Members)

Central Region (62,777 Members)

Eastern Missouri (234,298 Members)



Income Guidelines for MC+ for Kids, Medical Assistance for Families, and Temporary Assistance

Source: Missouri Department of Social Services, Family Support Division

INCOME GUIDELINES
FOR MC+, MAF AND TEMPORARY ASSISTANCE

NUMBER OF PERSONS	TEMPORARY ASSISTANCE			MEDICAL ASSISTANCE FOR FAMILIES	NON-CHIP MC+ AGES 6-18	NON-CHIP MC+ AGES 1 - 5	NON-CHIP MC+ UNDER AGE 1 & MC+ FOR PREGNANT WOMEN	MC+ CHIP GROUPS (UNINSURED CHILDREN) THROUGH AGE 18			FOOD STAMPS
		Eligibility Test	Net Income Limit/Max.	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	GROSS INCOME MAX FEDERAL POVERTY LEVEL			GROSS MAX
	Gross Max.	Cons. Std.	Grant Amt	77% of Federal Poverty Level	100% of Federal Poverty Level	133 % of Federal Poverty Level	185% of Federal Poverty Level	NO-COST 185%	CO-PAY 225%	PREM 300%	130% of FPL FPL
1	727	393	136	577	749	996	1385	1385	1684	2245	973
2	1254	678	234	778	1010	1344	1869	1869	2273	3030	1313
3	1565	846	292	980	1272	1692	2353	2353	2862	3816	1654
4	1832	990	342	1181	1534	2040	2837	2837	3450	4600	1994
5	2078	1123	388	1383	1795	2388	3321	3321	4039	5385	2334
6	2307	1247	431	1584	2057	2736	3805	3805	4628	6171	2674
7	2538	1372	474	1786	2319	3084	4289	4289	5217	6955	3014
8	2755	1489	514	1987	2580	3432	4773	4773	5805	7740	3354
9	2971	1606	554	2189	2842	3780	5258	5258	6394	8526	3695
10	3186	1722	595	2390	3104	4128	5742	5742	6983	9310	4036
11	3402	1839	635	2592	3365	4476	6226	6226	7572	10095	4377
12	3619	1956	675	2793	3627	4824	6710	6710	8161	10880	4718

Temporary Assistance:

If under gross income limit, deduct child care expenses and $90 work standard and compare to consolidated standard.
If under the consolidated standard, income after allowable deductions, must be under the net income limit to be eligible.

Medical Assistance for Families, MC+ for Pregnant Women, and Non-CHIP Children:

Deduct child care expenses and $90 for each wage earner from gross income - compare to poverty level.

CHIP groups:

Gross income must be under maximum. There are no deductions.

** Transitional Medical Assistance eligibility (for the second six-month period of eligibility) is determined by subtracting childcare expenses from earned income and comparing the result to 185% of the current federal poverty level.

Eligibility Requirements and Covered Services for Medicaid Family Healthcare Programs

Source: Missouri Department of Social Services, Family Support Division

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
1. Title: MC+ for children Note: This description includes both SCHIP and non-SCHIP children. SCHIP children are those with net family income above the following: • 185% FPL for children under age 1 • 133% FPL for ages 1- 5 • 100% FPL for ages 6 –18.	Healthcare coverage for children under 19 years of age. Coverage is provided through a Managed Care plan in some counties. Children in families with income between 185% and 225% FPL must pay $5 per provider visit. Children in families with income between 225% and 300% FPL must pay $10 per provider visit and $9 for prescriptions.	Under 19. SSN. Live in Missouri. US Citizen/Eligible Alien. Parent cooperates in obtaining medical support. Gross family income less than 300% of Federal Poverty Level (FPL) for household size. Children with net family income above the following must be uninsured and family net worth must be less than $250,000: • 185% FPL for children under age 1 • 133% FPL for ages 1- 5 • 100% FPL for ages 6 –18. Children in families with gross income over 225% FPL cannot have access to affordable health insurance ($299/mo.) and the family must pay a monthly premium of between $59 and $225 based on family size and income.
2. Title: Medical Assistance for Families (MAF)	MC+ healthcare coverage for families with income that does not exceed 77% FPL. Coverage is provided through a Managed Care plan in some counties.	Eligible child under 19 in the home. SSN. Live in Missouri. US Citizen/Eligible Alien. Cooperate in obtaining medical support for the children. Net family income does not exceed 77% FPL for household size
3. Title: MC+ for pregnant women	Healthcare coverage during pregnancy plus 2 months of postpartum following the month the pregnancy ends. Coverage is provided through a Managed Care plan in some counties.	Verified Pregnancy. SSN. Live in Missouri. US Citizen/Eligible Alien. Net family income does not exceed 185% FPL for household size (including unborn child).
4. Title: Extended Women's Health Services Note: This is a Section 1115 waiver group.	Up to 12 months of women's health services for women who lose MC+ healthcare coverage two months after a pregnancy ends. Coverage is limited to family planning, and testing and treatment of Sexually Transmitted Diseases.	Received MC+ coverage due to pregnancy. Uninsured.
5. Title: MC+(Medicaid) for newborns	Healthcare coverage through age 1. Coverage is provided through a Managed Care plan in some counties.	Mother was eligible for and received MC+ or Medicaid when child was born. Newborn remains in mother's home.

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
6. Title: Transitional Medical Assistance	Provides MC+ healthcare coverage to a family for up 12 months, after the closing of MAF case. Coverage is provided through a Managed Care plan in some counties.	Received MAF 3 of last 6 months preceding ineligibility. Become ineligible for MAF due to employment, increased earnings, or loss of earned income disregards. Return quarterly reports. Child under 19 in the home. To be eligible for the second 6 months earned income minus childcare costs cannot exceed 185% FPL for household size.
7. Title: Extended Transitional Medical Assistance Note: This is a Section 1115 waiver group.	Up to an additional 12 months of MC+ healthcare coverage for parents who complete their 12 months of Transitional Medical Assistance. Coverage is provided through a Managed Care plan in some counties. Required co-pays are $10 per provider visit and $5 for prescriptions.	Received 12 months of Transitional Medical Assistance. Child covered by MC+ in the home. Net family income does not exceed 100% of FPL for household size. Uninsured.
8. Title: Extended MAF for Child Support Closings	Provides MC+ healthcare coverage to a family for 4 months, after the closing of MAF case due to increased child support. Coverage is provided through a Managed Care plan in some counties.	Received MAF 3 of last 6 months preceding ineligibility. Become ineligible for MAF due to receipt of or increased income from child support or alimony.
9. Title: Refugee Medical Assistance	Up to 8 months of MC+ healthcare coverage for recipients of the Refugee Assistance program. Coverage is provided through a Managed Care plan in some counties.	Approved for the Refugee Assistance program.

Income and Asset Guidelines for the Elderly, Blind, Disabled, and those who need treatment for Breast or Cervical Cancer

Source: Missouri Department of Social Services, Family Support Division

Program	Individual Income Limit	Couple Income Limit	Individual Asset Limit	Couple Asset Limit
Medical Assistance Non-Spend down	$674	$909	$999.99	$2,000
Medical Assistance Spend down	Incurred Medical Expenses reduce income to $674	Incurred Medical Expenses reduce income to $909	$999.99	$2,000
Nursing Facility Vendor Payments	Available income paid for cost of care	N/A	$999.99	$2,000, or Division of Assets
Supplemental Nursing Care	Less than Nursing Home Base Rate	N/A	$999.99	$2,000
Home and Community Based Waiver	$985	N/A	$999.99	$2,000, or Division of Assets
MA for Workers with Disabilities (MA-WD)	$1,871	N/A	$999.99	N/A
Blind Pension	N/A	N/A	$20,000 Total Property	$20,000 Total Property
Supplemental Aid to the Blind	$609	N/A	$2,000	$4,000
General Relief	$181	$256	$999.99	$2,000
1619 (a)	$564	$846	$2,000	$4,000
1619 (b)	$1840	N/A	$2,000	$4,000
Breast and Cervical Cancer Treatment	N/A-BCCCP screening has income limits	N/A	N/A	N/A
Qualified Medicare Beneficiary	$749	$1,010	$4,000	$6,000
Specified Low Income Medicare Beneficiary	$898	$1,212	$4,000	$6,000
QI-1 - Qualifying Individual	$1,011	$1,364	$4,000	$6,000
Qualified Disabled Working Individuals	$1,497	$2,020	$4,000	$6,000

Eligibility Requirements and Covered Services for Medicaid for the Elderly, Blind, Disabled, and individuals who need treatment for Breast or Cervical Cancer

Source: Missouri Department of Social Services, Family Support Division

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
Medical Assistance Non-Spend down	Medicaid Covered Services	Social Security Number Live in Missouri US Citizen/Eligible Alien Elderly (65 and over), Blind or Permanently and Totally Disabled Available resources for Elderly and Disabled: Individual - less than $1000 Couple - $2000 or less Real and Personal Property for Blind: Individual – $2000 or less Couple - $4000 or less Maximum Income Individual - $674, Couple - $909 (adjusted annually)
Medical Assistance Spend down	Medicaid Covered Services that exceed the spend down amount.	All eligibility requirements are the same as MA non-spend down, except there is no income maximum. Each month meet a spend down equal to the amount by which income exceeds the non-spend down limit (Individual - $674, Couple - $909). The spend down may be met by incurring medical expenses or paying in to Division of Medical Services.
Vendor Payments for care in a Nursing Facility, Institution for the Mentally Retarded, State Mental Hospital (age 65 or older), or Psychiatric Hospital (under age 22)	Medicaid covered services including payment to the nursing facility above the amount the resident is expected to pay.	A resident is expected to pay all available income, except for medical insurance premiums and a $30 monthly personal needs allowance, to the nursing facility. However, allotment of income may allow for some or all of that spouse's income to be allotted to the community spouse or certain dependents. Social Security Number Live in Missouri US Citizen/Eligible Alien Elderly (65 and over), Blind or Permanently and Totally Disabled Require nursing facility level of care Available resources *Individual – less than $1000 Couple - $2000 or less (both institutionalized) Can't transfer property without receiving fair and valuable consideration, with some exceptions * after Division of Assets
Division of Assets (Prevention of Spousal Impoverishment)	Division of Assets provides a way to set aside a portion of a married couples assets when one spouse enters a nursing facility and the other spouse remains in the community. It also applies when one spouse is eligible under HCB criteria.	Married couple A spouse resides in a Medicaid certified bed or in a hospital for at least 30 days and the other spouse resides in the community

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
Supplemental Nursing Care	Pays a monthly cash grant to eligible persons residing in a licensed residential care facility. RCF-I - $156, RCF II - $292, or Non-Medicaid ICF/SNF - $390 plus a $25.00 personal needs allowance. Medicaid covered services.	Age 21 or over Social Security Number Live in Missouri US Citizen/Eligible Alien Elderly (65+), or Blind or Permanently and Totally Disabled Available resources Individual - less than $1,000, Couple - $2,000 or less Income less than nursing home's basic charge If in Non-Medicaid ICF/SNF must require nursing facility level of care.
Home and Community Based Waiver Program (HCB)	Medicaid covered services.	Age 63 or over Maximum income limit of $985 for person needing HCB (adjusted annually) Social Security Number US Citizen/Eligible Alien Live in Missouri Available resources *Individual – less than $1000 If a married couple and both require HCB services - $2000 or less Certified by Division of Aging for participation in HCB waiver Require nursing home level of care Can't transfer property without receiving fair and valuable consideration, with some exceptions *After Division of Assets
Medical Assistance for Workers with Disabilities	Medicaid covered services	Social Security Number Live in Missouri US Citizen/Eligible Alien Permanently and Totally Disabled or would be if earnings were not considered Employed Age 16 through 64 Available resources less than $1000; excluding spouse's assets up to $100,000, half of marital assets, independent living development accounts and retirement accounts funded by earnings while participating in the program Maximum gross income of $1,871 per mo., excludes a spouse's income up to $8,333.33 per mo. Premium – individual's with gross income above $1,123 per month must pay a monthly premium of $48 to $124. (income limits and premium amounts are adjusted annually)
Blind Pension	Medicaid covered services Monthly cash grant of $470	US Citizen/Eligible Alien Live in Missouri Cannot be eligible for or receiving SSI Must be 18 or older Have total property less than $20,000 (homestead is exempt) Meet the state definition of blindness.

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
General Relief	State funded medical assistance which provides a restricted package of Medicaid covered services	US Citizen/Eligible Alien Live in Missouri Must apply for SSI Social Security Number Must be unemployable for at least 90 days Have available resources less than $1000 if single, 2000 for a couple Have earned income less than $80 per month. Income of relatives living in the household may be considered. Maximum income limit Individual - $181 Couple - $256
Medical Assistance based on Section 1619 (a) of the Social Security Act	Medicaid covered services	1619 Status is determined by the Social Security Administration. Must continue to be blind or disabled. Continue to meet all SSI requirements other than earnings. Have earnings above substantial gainful activity amount but below federal benefit rate. Must have received Medicaid in the month prior to gaining 1619 status.
Medical Assistance based on Section 1619 (b) of the Social Security Act	Medicaid covered services	1619 status is determined by the Social Security Administration. Must continue to be blind or disabled Must continue to meet all SSI requirements other than earnings. Not have sufficient earnings to replace SSI cash benefits, Medicaid benefits and publicly-funded personal or attendant care that would be lost due to the person's earnings. A threshold of $1840 is utilized, but an individualized threshold can be calculated if earnings exceed $1840. Must have received Medicaid in the month prior to gaining 1619 status.
Medical Assistance for Women in need of Breast or Cervical Cancer Treatment	All Medicaid Covered Services. Coverage is NOT limited to cancer treatment.	Social Security Number Live in Missouri U.S. Citizen/Eligible Alien Under age 65 Screened for breast or cervical cancer by Missouri's Breast and Cervical Cancer Control Project (BCCCP) (Note: The BCCCP Program has requirements including income limits that must be met to get the screening.) Need treatment for breast or cervical cancer Uninsured or has health insurance that does not cover breast or cervical cancer treatment
QMB – Qualified Medicare Beneficiary	Pays Medicare Part B premium, in some cases Part A, pays co-payments and deductibles for Medicare approved services.	US Citizen/Eligible Alien Live in Missouri Social Security Number Must be receiving Part A Medicare Have available resources less than $4,000 if single, $6,000 for a couple Monthly income less than $749 if single or $1010 for a couple
SLMB – Specified Low Income Medicare Beneficiary	Pays Medicare Part B Premium only.	Same as QMB, except monthly income less than $898 if single or $1212 for a couple. (adjusted annually)
QI – 1 Qualifying Individual	Pays Medicare Part B Premium only.	Same as QMB, except monthly income less than $1011 if single or $1364 for couple. (adjusted annually)

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
Qualified Disabled Working Individuals (QDWI)	Pays Medicare Part A Premium only.	QDWI status is determined by the Social Security Administration Under age 65 Lost free Medicare Part A due to employment Remain disabled Enrolled in Medicare Part A Income cannot exceed $1497 for individuals $2020 for couple Available resources Individual $4000 Couple $6000 US Citizen/Eligible Alien Live in Missouri Social Security Number

Top 25 Medications by Dollars, Fiscal Year 2003

Source: Missouri Department of Social Services, Division of Medical Services, Pharmacy Program

Summary Report for Periods: 07/2002 to 02/2003

Line of Business: ALL

Reporting Detail: Top 25 Products Ranked by Paid and Minor Drug Classes

Drug Class/Drug	Paid	Rx	User Months	Paid PUPM	Paid/Rx	% Pgm Paid	% Growth
ANTIPSYCHOTICS	$82,549,605	457,240	421,834	$195.69	$180.54	12.8%	0.28%
ANALGESICS	$64,021,091	1,331,109	1,166,945	$54.86	$48.10	10%	-0.6%
ANTIDEPRESSANTS	$54,713,891	925,301	918,316	$59.58	$59.13	8.5%	0.36%
ANTICONVULSANTS	$41,663,589	521,910	504,791	$82.54	$79.83	6.5%	1.21%
ANTILIPEMICS	$23,636,120	277,026	282,211	$83.75	$85.32	3.7%	0.27%
ANTI-ULCER	$22,063,172	416,173	412,310	$53.51	$53.01	3.4%	-0.5%
IMMUNOLOGICAL/BIOLOGICAL	$19,902,251	35,650	34,538	$576.24	$558.27	3.1%	5.88%
ANTIHISTAMINES	$19,871,924	430,957	423,057	$46.97	$46.11	3.1%	-2.4%
ANTIVIRALS	$17,961,079	55,568	53,931	$333.04	$323.23	2.8%	0.78%
BETA2 AGONISTS	$17,304,322	387,911	360,825	$47.96	$44.61	2.7%	1.88%
ANGIOTENSIN-MODULATING	$16,116,019	415,582	419,211	$38.44	$38.78	2.5%	-0.91%
CNS AGENTS: OTHER	$13,040,086	229,646	217,377	$59.99	$56.78	2%	1.06%
RESPIRATORY: OTHER	$12,752,454	184,072	177,340	$71.91	$69.28	2%	1.02%
CALCIUM CHANNEL BLOCK	$12,742,624	259,158	260,974	$48.83	$49.17	2%	-1.18%
ANTIANXIETY/SEDATIVES	$11,961,144	435,653	408,054	$29.31	$27.46	1.9%	-0.73%
EENT	$11,601,180	284,128	270,980	$42.81	$40.83	1.8%	0.18%
SEX HORMONES	$10,992,868	344,051	353,843	$31.07	$31.95	1.7%	-0.48%
MISC THERAPEUTIC DRUGS	$10,208,791	427,821	486,265	$20.99	$23.86	1.6%	-0.89%
GENITO-URINARY AGENTS	$9,949,690	125,905	124,730	$79.77	$79.03	1.6%	0.4%
TOPICAL AGENTS	$9,492,369	313,013	277,611	$34.19	$30.33	1.5%	0.72%
CARDIOVASCULAR: OTHER	$8,872,090	340,193	340,188	$26.08	$26.08	1.4%	-1.68%
ANTIPLATELET AGENTS	$8,622,730	81,265	81,815	$105.39	$106.11	1.3%	0.84%
THIAZOLIDINEDIONES	$8,480,321	66,884	67,842	$125.00	$126.79	1.3%	-0.78%
INSULINS	$7,775,037	134,108	125,392	$62.01	$57.98	1.2%	0.83%
QUINOLONES	$7,661,822	100,465	90,990	$84.21	$76.26	1.2%	1.98%
Totals:	$523,956,271	8,580,789	8,281,368	$63.27	$61.06	81.4%	0.24%

Other States' Cost Containment Activities – Benefits and Eligibility – Fiscal Years 2003 and 2004

Source: States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 Results from a 50-State Survey, Prepared by Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, and Victoria Wachino. The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. September 2003. http://www.kff.org/medicaid/kcmu4137report.cfm

Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2003

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Co pays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama	X	X					X		
Alaska	X	X	X	X				X	
Arizona	X		X	X					
Arkansas	X	X		X					X
California	X	X	X					X	
Colorado	X	X	X	X			X	X	X
Connecticut	X	X	X	X	X			X	
Delaware	X	X			X				
District of Columbia	X	X						X	
Florida	X	X	X	X		X		X	X
Georgia	X	X					X		X
Hawaii	X								
Idaho	X	X	X			X	X		
Illinois	X	X			X			X	
Indiana	X	X	X	X		X		X	X
Iowa	X	X		X					
Kansas	X	X	X	X	X				
Kentucky	X	X		X	X		X		X
Louisiana	X	X		X		X	X		X
Maine	X	X							
Maryland	X	X			X				
Massachusetts	X	X	X	X	X			X	
Michigan	X	X							
Minnesota	X	X							
Mississippi	X	X	X	X	X		X	X	
Missouri	X	X		X			X	X	
Montana	X	X	X		X				
Nebraska	X	X		X	X				
Nevada	X	X		X					
New Hampshire	X	X					X		
New Jersey	X							X	
New Mexico	X	X							
New York	X	X						X	
North Carolina	X		X	X	X				
North Dakota	X	X	X	X	X				X
Ohio	X	X		X				X	
Oklahoma	X	X	X	X	X				
Oregon	X	X	X	X	X		X		X
Pennsylvania	X	X				X		X	X

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Co pays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Rhode Island	X	X		X			X		
South Carolina	X	X		X		X		X	
South Dakota		X							
Tennessee	X			X					
Texas	X	X						X	
Utah	X	X	X		X				
Vermont	X	X	X		X				
Virginia	X	X			X				
Washington	X	X		X			X	X	
West Virginia	X	X							
Wisconsin	X	X							
Wyoming	X	X					X	X	
Totals	**50**	**46**	**18**	**25**	**17**	**6**	**13**	**19**	**10**

Note: A blank indicates the state reported no action.
*Eligibility changes include instituting premiums and changes to application and enrollment processes.

DM/CM: Disease Management or Case Management Program
LTC: Long Term Care

Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2004

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Co pays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama	X	X							
Alaska	X	X		X				X	
Arizona	X			X					
Arkansas	X								
California	X	X					X	X	
Colorado	X		X	X	X			X	
Connecticut	X	X			X			X	
Delaware	X				X				
District of Columbia	X	X				X			
Florida	X	X	X		X	X			
Georgia	X	X	X		X				
Hawaii	X	X							
Idaho	X	X					X		
Illinois	X	X							X
Indiana	X	X		X	X	X	X		
Iowa	X	X		X	X				
Kansas	X	X					X	X	
Kentucky	X	X		X					
Louisiana	X	X	X						
Maine	X	X			X			X	
Maryland	X	X						X	
Massachusetts	X	X		X	X		X		X
Michigan	X	X	X		X			X	X
Minnesota	X	X	X	X	X				
Mississippi	X	X	X				X		
Missouri	X	X	X				X		
Montana							X		
Nebraska	X		X	X					
Nevada	X	X	X			X	X	X	
New Hampshire	X	X	X		X		X	X	
New Jersey	X	X	X		X		X	X	
New Mexico	X	X						X	
New York	X	X						X	
North Carolina	X	X		X		X			
North Dakota	X	X	X	X	X		X		
Ohio	X	X	X		X		X		
Oklahoma	X	X					X	X	
Oregon	X	X	X			X	X		X
Pennsylvania	X	X	X		X			X	
Rhode Island	X					X			
South Carolina	X	X				X			
South Dakota		X							
Tennessee	X	X					X	X	
Texas	X	X	X	X		X	X	X	
Utah	X	X	X	X					
Vermont	X	X		X	X				

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Co pays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Virginia	X	X	X	X	X				
Washington	X	X	X	X	X				X
West Virginia	X	X		X	X	X			
Wisconsin	X	X		X	X	X		X	
Wyoming	X	X					X	X	
Totals	**49**	**44**	**20**	**18**	**21**	**11**	**18**	**19**	**5**

Note: A blank indicates the state reported no action.
*Eligibility changes include instituting premiums and changes to application and enrollment processes.

DM/CM: Disease Management or Case Management
LTC: Long-Term Care

Other States' Cost Containment Activities – Pharmacy – Fiscal Years 2003 and 2004

Source: *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 Results from a 50-State Survey,* Prepared by Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, and Victoria Wachino. The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. September 2003. http://www.kff.org/medicaid/kcmu4137report.cfm

Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of FY 2003

State	AWP	New Or Lower State MAC	Reduction In Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limits on the Number of Scripts
Alabama							
Alaska				X			X
Arizona							
Arkansas							
California	X		X	X		X	
Colorado	X			X			
Connecticut		X	X				
Delaware	X	X		X			
District of Columbia				X	X		
Florida							
Georgia		X	X	X			
Hawaii							
Idaho		X		X			
Illinois	X	X	X	X	X	X	
Indiana				X	X		
Iowa		X		X			
Kansas	X	X	X	X	X	X	X
Kentucky	X	X			X		
Louisiana				X	X	X	X
Maine	X				X	X	
Maryland			X				
Massachusetts	X	X	X	X	X		
Michigan		X		X			
Minnesota	X	X		X	X	X	
Mississippi	X		X				
Missouri		X		X			
Montana	X						
Nebraska	X			X			
Nevada	X			X			
New Hampshire				X			
New Jersey							
New Mexico			X				
New York				X			
North Carolina		X					
North Dakota							
Ohio				X	X	X	

State	AWP	New Or Lower State MAC	Reduction In Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limits on the Number of Scripts
Oklahoma				X			X
Oregon	X			X	X		
Pennsylvania				X			
Rhode Island				X			
South Carolina				X	X	X	
South Dakota		X					
Tennessee							
Texas		X					
Utah	X			X			
Vermont		X		X		X	
Virginia	X						
Washington	X	X		X	X	X	
West Virginia					X	X	
Wisconsin				X			
Wyoming		X		X			
TOTAL	**17**	**18**	**9**	**32**	**15**	**11**	**5**

Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of Fiscal Year 2004

State	AWP	New Or Lower State MAC	Reduction In Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Contract with a PBM	Limits on the Number of Scripts
Alabama				X		X		
Alaska	X	X			X			
Arizona								
Arkansas								
California		X		X				
Colorado								
Connecticut				X	X	X		
Delaware								
District of Columbia				X	X			
Florida		X				X		
Georgia		X		X	X	X		
Hawaii								
Idaho		X		X	X			
Illinois		X		X	X	X		
Indiana		X		X	X			
Iowa	X		X	X	X			
Kansas		X		X	X	X	X	
Kentucky					X	X		
Louisiana				X	X	X		
Maine								
Maryland	X				X	X		X
Massachusetts	X	X		X	X		X	X
Michigan		X			X			
Minnesota	X	X		X	X	X		
Mississippi		X		X	X			
Missouri		X				X		
Montana								
Nebraska								
Nevada		X			X	X		
New Hampshire	X							
New Jersey						X		
New Mexico								
New York	X				X	X	X	X
North Carolina								
North Dakota			X	X			X	
Ohio				X	X	X		
Oklahoma				X	X			
Oregon				X	X	X		
Pennsylvania								
Rhode Island								
South Carolina				X	X			
South Dakota				X				

State	AWP	New Or Lower State MAC	Reduction In Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Contract with a PBM	Limits on the Number of Scripts
Tennessee					X	X	X	
Texas			X	X	X	X		X
Utah					X			
Vermont				X	X			
Virginia			X	X	X	X		
Washington		X		X	X	X		
West Virginia		X			X			
Wisconsin	X		X	X	X	X		
Wyoming		X		X	X			
TOTAL	**8**	**17**	**5**	**26**	**31**	**21**	**5**	**4**

Nursing Home Reimbursement Rates

Source: Compiled from the 1998 State Data Book on Long Term Care Program and Market Characteristics. Charlene Harrington, James H. Swan, Valerie Wellin, Wendy Clemena, and Helen M. Carrillo. http://cms.hhs.gov/medicaid/services/ltcdata.asp

STATE	AVERAGE REIMBURSEMENT RATE, 1998	CASE MIX USED?
Alabama	$98.69	No
Alaska	$253.48	No
Arizona	$88.23	Yes
Arkansas	$61.98	Yes
California	$83.12	No
Colorado	$101.55	Yes✧
Connecticut	$133.83	No
Delaware	$108.56	Yes
District of Columbia	$179.94	No
Florida	$97.99	Yes▲
Georgia	$81.08¤	No
Hawaii	$130.42	No
Idaho	$94.26	No
Illinois	$74.23	Yes
Indiana	$80.32	Yes
Iowa	$71.70*	No
Kansas	$71.94	Yes
Kentucky	$88.81	Yes
Louisiana	$65.54	No
Maine	$115.77	Yes
Maryland	$98.88	Yes
Massachusetts	$116.63	Yes
Michigan	$91.49	No
Minnesota	$106.47	Yes
Mississippi	$80.60	Yes
Missouri	$88.34	No
Montana	$87.54	Yes
Nebraska	$81.96	Yes
Nevada	$86.71	Yes
New Hampshire	$115.07	Yes•
New Jersey	$115.76	Yes

✧ Colorado was due to begin using case-mix adjusters in July, 2000.
▲ Florida implemented a case-mix component on April 1, 1999.
¤ This average represents a weighted average of hospital-based and free-standing facilities. $78.443 is the average reimbursement rate of free-standing facilities only, and $96.55 is the average of hospital-based facilities only.
* This is the average reimbursement rate for Iowa nursing facilities. The average reimbursement rate for Iowa skilled nursing facilities is $125.59.
• Implementation of case-mix planned for New Hampshire for January 1, 1999.

STATE	AVERAGE REIMBURSEMENT RATE, 1998	CASE MIX USED?
New Mexico	$129.04	No
New York	$158.93	Yes
North Carolina	$95.12	No
North Dakota	$94.31	Yes
Ohio	$108.96	Yes
Oklahoma	$64.20	No
Oregon	$89.18	No
Pennsylvania	$114.23	Yes
Rhode Island	$103.97	No
South Carolina	$82.75	Yes
South Dakota	$76.96	Yes
Tennessee	$83.16	No
Texas	$71.69□	Yes
Utah	$83.11	No
Vermont	$104.10	Yes
Virginia	$79.47	Yes
Washington	$116.00	No
West Virginia	$106.27	Yes
Wisconsin	$91.07	Yes
Wyoming	$93.78	No

Notes:
The numbers contained in the table above represent each state's overall average reimbursement rate for nursing facilities. Numerous factors, including payment and rate setting methodology, make estimating these average rates difficult.

Case-Mix Reimbursement is defined as follows: "Systems that require a method for assigning scores or "weights" to different residents, reflecting the relative costliness of caring for different residents, based on measurable characteristics (e.g., dependencies in activities of daily living). These weights are incorporated if rate setting is at the facility or patient level. Systems that pay different rates for different levels of care are classified here as having case-mix reimbursement."

□ This is the average reimbursement rate from September 1, 1997 through December 31, 1997. From January 1, 1997 through August 31, 1997 the average reimbursement rate was $70.83.

Missouri Family Support Division and Division of Medical Services Management Report

Source: Missouri Department of Social Services, Family Support Division and Division of Medical Services

Number of Eligibles Enrolled

MEDICAID ROLLS	
Jan-93	510,788
Jan-94	560,891
Jan-95	592,705
Jan-96	592,961
Jan-97	588,925
Mar-97	590,293
Apr-97	587,403
May-97	583,396
Jun-97	580,587
Jul-97	577,979
Aug-97	577,943
Sep-97	578,842
Oct-97	578,429
Nov-97	580,315
Dec-97	579,450
Jan-98	581,098
Feb-98	585,175
Mar-98	585,758
Apr-98	580,778
May-98	579,631
Jun-98	576,415
Jul-98	573,016
Aug-98	574,850
Sep-98	580,363
Oct-98	588,181
Nov-98	598,930
Dec-98	604,734
Jan-99	
Feb-99	620,480
Mar-99	639,723
Apr-99	656,709
May-99	669,246
Jun-99	675,868
Jul-99	683,450
Aug-99	692,989
Sep-99	699,304
Oct-99	707,010
Nov-99	714,299
Dec-99	721,515
Jan-00	728,923
Feb-00	733,764
Mar-00	738,308
Apr-00	745,416
May-00	749,821
Jun-00	751,509
Jul-00	756,241
Aug-00	761,571
Sep-00	769,612
Oct-00	776,973
Nov-00	784,795
Dec-00	792,224

MEDICAID ROLLS	
Jan-01	834,532
Feb-01	844,322
Mar-01	850,858
Apr-01	858,079
May-01	833,274
Jun-01	838,046
Jul-01	841,907
Aug-01	846,687
Sep-01	853,184
Oct-01	857,436
Nov-01	862,697
Dec-01	868,619
Jan-02	781,506
Feb-02	881,520
Mar-02	888,866
Apr-02	894,086
May-02	898,510
Jun-02	884,871
Jul-02	905,683
Aug-02	877,996
Sep-02	902,743
Oct-02	915,651
Nov-02	917,568
Dec-02	929,605
Jan-03	932,355
Feb-03	926,192
Mar-03	942,197
Apr-03	945,017
May-03	950,204
Jun-03	950,694
Jul-03	956,228
Aug-03	962,211
Sep-03	969,149
Oct-03	975,288
Nov-03	978,495

Division of Medical Services – Fiscal Year 2003 Expenditures

Source: Missouri Department of Social Services, Division of Medical Services

	TOTAL	General Revenue	Federal Funds	Provider Taxes	Other Funds
Pharmacy	$932,961,078	$228,966,789	$560,703,924	$51,350,192	$91,940,173
Hospitals	$758,856,188	$10,217,542	$458,785,778	$227,603,358	$62,249,510
Nursing Facilities	$719,173,688	$77,118,258	$441,710,920	$114,053,481	$86,291,029
Managed Care	$656,244,313	$109,499,833	$401,134,495	$111,366,869	$34,243,116
Mental Health & State Institutions	$209,427,183	$-	$209,427,183	$-	$-
In-Home Services	$308,766,299	$118,704,524	$189,051,777	$-	$1,009,998
Physician-Related	$247,619,541	$76,299,216	$162,422,160	$-	$8,898,165
EPSDT Services	$133,653,751	$42,587,903	$85,587,895	$380,557	$5,097,397
Rehab & Specialty	$129,352,442	$46,563,722	$79,026,674	$-	$3,762,046
All Other	$91,851,448	$15,073,511	$55,274,967	$3,218,265	$18,284,705
DMS TOTAL	**$4,187,905,931**	**$725,031,298**	**$2,643,125,773**	**$507,972,722**	**$311,776,139**
		17.31%	*63.11%*	*12.13%*	*7.44%*
DMH-Mental Health & State Institutions	$372,405,139				
GRAND TOTAL	**$4,560,311,070**				

2003 Annual Federal Poverty Income Guidelines

Compiled by Amy Woods
Research Staff
Missouri House of Representatives

Percent of Poverty	Family Size							
	1	2	3	4	5	6	7	8
100%	8,980.00	12,120.00	15,260.00	18,400.00	21,540.00	24,680.00	27,820.00	30,960.00
120%	10,776.00	14,544.00	18,312.00	22,080.00	25,848.00	29,616.00	33,384.00	37,152.00
133%	11,943.40	16,119.60	20,295.80	24,472.00	28,648.20	32,824.40	37,000.60	41,176.80
135%	12,123.00	16,362.00	20,601.00	24,840.00	29,079.00	33,318.00	37,557.00	41,796.00
150%	13,470.00	18,180.00	22,890.00	27,600.00	32,310.00	37,020.00	41,730.00	46,440.00
175%	15,715.00	21,210.00	26,705.00	32,200.00	37,695.00	43,190.00	48,685.00	54,180.00
185%	16,613.00	22,422.00	28,231.00	34,040.00	39,849.00	45,658.00	51,467.00	57,276.00
200%	17,960.00	24,240.00	30,520.00	36,800.00	43,080.00	49,360.00	55,640.00	61,920.00
225%	20,205.00	27,270.00	34,335.00	41,400.00	48,465.00	55,530.00	62,595.00	69,660.00
250%	22,450.00	30,300.00	38,150.00	46,000.00	53,850.00	61,700.00	69,550.00	77,400.00
275%	24,695.00	33,330.00	41,965.00	50,600.00	59,235.00	67,870.00	76,505.00	85,140.00
300%	26,940.00	36,360.00	45,780.00	55,200.00	64,620.00	74,040.00	83,460.00	92,880.00

Federal Poverty Guidelines are updated annually in February by the Department of Health and Human Services in the Federal Register.

Source: Based on the Income Guidelines published in the Federal Register, Volume 68, No. 26, February 7, 2003.

Medicaid Covered Services State-by-State

Source: Compiled from Medicaid Benefits Database, Kaiser Commission on Medicaid and the Uninsured and the National Conference of State Legislatures, The Henry J. Kaiser Family Foundation. Survey includes state information as of January 2003. www.kff.org/medicaidbenefits/

	MO	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI
Clinic Services - Ambulatory Surgery Center	x	x		x	x	x	x		x	x	x	x	
Clinic Services - Public and Mental Health Clinics	x	x	x	x		x	x	x	x		x	x	x
Religious Non-Medical Health Care Institution and Practitioner Services				x		x					x		
Dental Services	x		x	x		x		x			x	x	x
Dentures	x			x		x		x					
Eyeglasses	x	x	x	x	x	x	x			x	x	x	x
Hearing Aids	x		x			x		x			x		x
Services for Speech, Language and Hearing Disorders	x		x			x	x						x
Medical Equipment and Supplies	x	x	x	x	x	x	x	x	x	x	x	x	x
Prosthetic and Orthotic Devices	x	x	x	x	x	x	x	x	x	x	x	x	x
Diagnostic, Screening, and Preventive Services			x	x				x		x		x	x
Rehabilitation Services - Mental Health and Substance Abuse	x	x	x	x	x	x	x		x		x		
Certified Registered Nurse Anesthetist		x		x	x	x	x						
Chiropractor Services						x					x		
Optometrist Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Podiatrist Services	x		x	x	x	x	x		x	x	x	x	x
Psychologist Services				x		x							x
Prescription Drugs	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Therapy Services	x		x	x		x				x			x
Occupational Therapy Services	x		x			x							x
Ambulance Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Non-Emergency Medical Transportation Services		x	x	x	x	x	x	x	x		x	x	x
Hospice Care	x	x	x		x	x	x		x	x	x	x	x
Personal Care Services	x		x		x	x				x			
Private Duty Nursing				x	x		x		x	x			
Targeted Case Management	x	x	x	x	x	x	x	x		x	x	x	x
Inpatient Psychiatric Services for those under age 21	x	x	x	x	x	x	x	x	x	x			x
Inpatient Hospital, Nursing Facility, and Intermediate Care Facility Services in Institutions for Mental Disease for those 65 and older	x	x	x	x		x	x	x	x	x	x		
Institutions for Mental Disease	x	x	x	x		x	x	x	x	x	x		
Intermediate Care Facility Services for the Mentally Retarded	x	x	x	x	x	x	x	x	x	x	x	x	x

	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN
Clinic Services - Ambulatory Surgery Center	x		x	x	x	x	x			x	x	x
Clinic Services - Public and Mental Health Clinics	x	x	x	x	x	x	x	x	x	x	x	x
Religious Non-Medical Health Care Institution and Practitioner Services			x					x				
Dental Services	x	x	x	x	x	x	x	x	x	x	x	x
Dentures	x	x	x	x	x		x	x		x	x	x
Eyeglasses	x	x	x	x	x			x			x	x
Hearing Aids	x	x	x	x	x	x				x	x	x
Services for Speech, Language and Hearing Disorders	x	x	x		x		x	x		x		x
Medical Equipment and Supplies	x	x	x	x	x	x	x	x	x	x	x	x
Prosthetic and Orthotic Devices	x	x	x	x	x	x		x			x	x
Diagnostic, Screening, and Preventive Services	x	x	x			x		x				
Rehabilitation Services - Mental Health and Substance Abuse	x	x	x		x	x	x	x	x	x	x	x
Certified Registered Nurse Anesthetist	x			x	x	x	x		x		x	x
Chiropractor Services	x	x	x	x		x		x			x	x
Optometrist Services	x	x	x	x	x	x	x	x	x	x	x	x
Podiatrist Services	x	x	x	x		x	x	x	x	x	x	x
Psychologist Services			x	x	x			x		x		x
Prescription Drugs	x	x	x	x	x	x	x	x	x	x	x	x
Physical Therapy Services	x	x			x			x	x	x		x
Occupational Therapy Services		x	x		x			x		x		x
Ambulance Services	x	x	x	x	x	x	x	x	x	x	x	x
Non-Emergency Medical Transportation Services	x	x	x	x	x	x	x	x	x	x	x	x
Hospice Care	x	x	x	x	x	x	x	x	x	x	x	x
Personal Care Services	x				x			x	x	x	x	x
Private Duty Nursing			x					x		x		x
Targeted Case Management	x	x	x	x	x	x	x	x	x	x	x	x
Inpatient Psychiatric Services for those under age 21	x	x	x	x	x	x	x	x	x	x	x	x
Inpatient Hospital, Nursing Facility, and Intermediate Care Facility Services in Institutions for Mental Disease for those 65 and older	x	x	x	x	x	x	x	x	x	x	x	x
Institutions for Mental Disease	x	x	x	x	x	x	x	x	x	x	x	x
Intermediate Care Facility Services for the Mentally Retarded	x	x	x	x	x	x	x	x	x	x	x	x

	MS	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR
Clinic Services - Ambulatory Surgery Center	x	x	x	x		x	x			x	x	x	x
Clinic Services - Public and Mental Health Clinics	x	x	x	x	x	x	x	x	x	x	x	x	x
Religious Non-Medical Health Care Institution and Practitioner Services	x					x					x		x
Dental Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Dentures	x	x	x	x		x	x	x	x	x	x		x
Eyeglasses	x	x	x	x	x	x	x	x	x	x	x		x
Hearing Aids		x	x	x	x	x	x	x					x
Services for Speech, Language and Hearing Disorders		x	x	x	x		x	x		x	x		x
Medical Equipment and Supplies	x	x	x	x	x	x	x	x	x	x	x	x	x
Prosthetic and Orthotic Devices		x	x	x	x	x	x	x		x	x		x
Diagnostic, Screening, and Preventive Services		x	x	x	x				x	x		x	x
Rehabilitation Services - Mental Health and Substance Abuse	x	x	x	x	x	x	x	x	x		x	x	x
Certified Registered Nurse Anesthetist		x	x				x		x				x
Chiropractor Services	x		x		x	x			x	x	x		x
Optometrist Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Podiatrist Services	x	x	x		x	x	x		x	x	x	x	x
Psychologist Services		x	x		x	x	x	x		x	x		
Prescription Drugs	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Therapy Services		x	x	x	x		x	x		x	x		x
Occupational Therapy Services		x	x	x	x		x	x		x	x		x
Ambulance Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Non-Emergency Medical Transportation Services	x	x	x	x		x		x	x	x			x
Hospice Care	x	x				x	x	x	x	x	x		x
Personal Care Services		x	x	x	x	x	x	x	x		x	x	x
Private Duty Nursing		x	x	x	x			x	x	x	x		x
Targeted Case Management	x	x	x	x	x	x	x	x	x	x	x	x	x
Inpatient Psychiatric Services for those under age 21	x	x	x	x	x	x		x	x	x	x	x	x
Inpatient Hospital, Nursing Facility, and Intermediate Care Facility Services in Institutions for Mental Disease for those 65 and older		x	x	x	x	x	x	x	x	x	x	x	x
Institutions for Mental Disease		x	x	x	x	x	x	x	x	x	x	x	x
Intermediate Care Facility Services for the Mentally Retarded	x	x	x	x	x	x	x	x	x	x	x	x	x

	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Clinic Services - Ambulatory Surgery Center	x	x	x	x	x	x			x	x	x	x	x
Clinic Services - Public and Mental Health Clinics	x		x	x	x		x	x	x		x		x
Religious Non-Medical Health Care Institution and Practitioner Services					x	x			x			x	
Dental Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Dentures	x	x		x			x			x		x	
Eyeglasses	x	x	x	x		x	x			x	x	x	x
Hearing Aids		x	x		x	x	x	x		x		x	
Services for Speech, Language and Hearing Disorders				x	x	x	x			x	x	x	x
Medical Equipment and Supplies		x	x	x	x	x	x	x	x	x		x	x
Prosthetic and Orthotic Devices		x	x	x	x		x	x	x	x	x	x	x
Diagnostic, Screening, and Preventive Services			x				x		x	x			
Rehabilitation Services - Mental Health and Substance Abuse		x	x	x	x	x	x	x	x	x	x	x	x
Certified Registered Nurse Anesthetist			x	x	x	x						x	x
Chiropractor Services	x		x	x		x	x				x	x	
Optometrist Services	x	x	x	x		x	x	x	x	x	x	x	x
Podiatrist Services	x	x	x	x	x	x	x	x	x	x	x	x	
Psychologist Services						x	x	x		x	x		x
Prescription Drugs	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Therapy Services				x	x	x	x			x	x	x	x
Occupational Therapy Services					x	x	x				x	x	x
Ambulance Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Non-Emergency Medical Transportation Services	x		x	x	x	x	x	x	x	x	x	x	x
Hospice Care	x	x	x		x	x	x	x	x	x	x	x	x
Personal Care Services		x		x			x			x	x	x	
Private Duty Nursing							x	x		x		x	
Targeted Case Management	x	x	x	x	x	x	x	x	x	x	x	x	x
Inpatient Psychiatric Services for those under age 21	x	x	x		x		x	x		x	x	x	
Inpatient Hospital, Nursing Facility, and Intermediate Care Facility Services in Institutions for Mental Disease for those 65 and older	x	x	x	x	x		x		x	x		x	x
Institutions for Mental Disease	x	x	x	x	x		x		x	x		x	x
Intermediate Care Facility Services for the Mentally Retarded	x	x	x	x	x	x	x	x	x	x	x	x	x

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[3] *Ibid*

[4] The Medicaid Resource Book, p. 83.

[5] House Interim Committee on Medicaid Cost Containment, Presentation by the Missouri Department of Social Services, September 9, 2003. *Also see:* Medicaid Enrollment in 50 States, Kaiser Commission on Medicaid and the Uninsured, July 2003.

[6] Myths and Facts About Medicaid, Article No. 3, " The State Children's Health Insurance Program", Missouri Hospital Association, January 2004

[7] Medical Assistance Budgets, Department of Social Services, Division of Budget and Finance, Letter from Brian Kinkade, November 13, 2002.

[8] State Health Facts Online, The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, http://www.statehealthfacts.org/

[9] Missouri Medicaid Briefing, Missouri Hospital Association. Presented to the House Interim Committee on Medicaid Cost Containment, October 10, 2003. *Hereinafter referred to as Missouri Medicaid Briefing.* See also Section 208.453 RSMo, *et seq.*

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[13] *Ibid*

[14] Missouri's Uninsured.

[15] January 2004 Cost of Living Adjustment, IM-156, December 3, 2003. Missouri Department of Social Services, Family Support Division. www.dss.mo.gov/dfs/iman/memos/memos_03/im156_03.html. *See also* 2004 Social Security Changes, Social Security Administration. *http://www.ssa.gov/pressoffice/factsheets/colafacts2004.htm.*

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[17] Monthly Management Report, Missouri Department of Social Services, Family Support Division and Division of Medical Services, December 2003.

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[19] *Ibid.*

[20] The Medicaid Resource Book.

[21] Puzzled by the Terminology? A Guide for Providers. Missouri Department of Social Services, Family Support Division. www.dss.mo.gov/dms/pages/puzzledterm.pdf. Revised September 8, 2003.

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[23] The Medicaid Resource Book.

[24] The Medicaid Resource Book.

[25] 42 C.F.R. §435.170

[26] The Medicaid Resource Book.

[27] Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government, Brian Bruen and John Holahan, Kaiser Commission on Medicaid and the Uninsured, November 2003.

[28] *Ibid.*

[29] 42 U.S.C. §1396r-5. *See also* 13 CSR 40-2.200.

[30] *Ibid.*

[31] Increase in Allotments and the Spousal Share, IM-155, Missouri Department of Social Services, Family Support Division, December 3, 2003. www.dss.mo.gov/dfs/iman/memos/memos_03/im155_03.html

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