State Health Watch

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In This Issue

New resources will combat major weaknesses in Medicaid fraud detection

How effectively does the Medicaid Statistical Information System (MSIS), the only nationwide Medicaid eligibility and claims information source, detect fraud, waste, and abuse? Not very, according to a new report which found the MSIS failed to capture data elements that can assist in fraud, waste, and abuse detection. Also, the MSIS fully quality-checked, validated, and released for use only 54% of quarterly data files submitted by states, and took an average of 18 months to evaluate and release the data for public use.

These are some of the findings of a report on the ability of the Medicaid Statistical Information System (MSIS), the only nationwide Medicaid eligibility and claims information source, to detect fraud, waste, and abuse.

The August 2009 report, *MSIS Data Usefulness for Detecting Fraud, Waste and Abuse,* from the Department of Health and Human Services' Office of Inspector General (HHS OIG), analyzed over 3,000 quarterly data files states submitted for analysis for fiscal years 2004-2006 to the Centers for Medicare & Medicaid (CMS).

According to CMS spokesman **Peter Ashkenaz**, "the findings were

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Ohio Medicaid faces steep growth; strives to protect access

Over the past 12 months, Ohio Medicaid has seen a 9% increase in enrollment, totaling 168,000 additional individuals on the program. Interestingly, though, 80% of that growth has been in the Healthy Families program, which covers parents, pregnant women, and children at low income levels. "So, the growth isn't coming from our expansion population. It's not our CHIP kids. We are seeing people who [have] never been on our program before, coming on not at the marginal end, but in our lowest growth categories," says **Heather Burdette**, MBA, assistant deputy director of Ohio Health Plans. "When I look at our base program, it's grown by 76,000 over the last 12 months. So, we have seen significant growth there."

Fiscal Fitness: How States Cope

Average monthly enrollment in Medicaid for FY 2008 was 1.88 million, and this is expected to grow to 2.05 million by FY 2010. "So, in over two years, we'll have added 270,000 individuals on an average monthly basis," says Ms. Burdette. "September 2009 was our 21st consecutive month of caseload growth.

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New resources

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not a surprise, as the report discusses previously identified gaps in MSIS. We will be working closely with state Medicaid directors as we look to expand and improve on the timeliness, quality, and depth of MSIS data."

Part of CMS' multipronged plan going forward involves incorporating lessons learned from individual state Medicaid program efforts, to inform efforts on the regional and national levels. "We are committed to deploying to states evidence-based tools that that they can use to combat waste, fraud, and abuse in Medicaid. We have made great headway in this area through conducting routine state program integrity reviews," says Mr. Ashkenaz.

Data from the State Program Integrity Assessment (SPIA), the first national data collection of state Medicaid program integrity activities, will establish a baseline assessment of each state that can be analyzed yearly to measure performance over time. Also, for the first time, states will have access to information on other states' program integrity activities.

CMS also plans to work with other entities, including the HHS OIG, to provide knowledge about program integrity to state Medicaid agencies. "OIG produces Management Implication Reports based on their audits and evaluations. CMS reviews those reports and will glean best practices for states from them," says Mr. Ashkenaz. "We see a stronger jurisdictional and cross-payer approach to attacking fraud and abuse. This means more work between Medicare and Medicaid, and between Medicaid and private insurers."

Mark Trail, a principal of Atlanta-based Health Management Associates and former director of Georgia Medicaid, notes that there is a difference between fraud and abuse. While the former requires criminal intent for personal gain from deliberate misrepresentation, the latter can include patterns of deviation from standards of practice; failure to properly price or bill for services; excessive use of services; failure to properly document service or level of service; and many other possible combinations.

"For most Medicaid agencies, it is difficult to find. First, because there are so many providers," says Mr. Trail. Most states have tens of thousands of Medicaid providers, and larger states may have in the hundred-thousand range, submitting millions of claims a month.

Most state detection systems do both prospective medical reviews, such as prior authorization for high-cost radiology services, and retrospective claims reviews looking for aberrant patterns of practice. "This can be accomplished by comparing the provider to similar peers," says Mr. Trail. For example, a physician may bill in the 90% range for the highest-cost evaluation and management codes, while most of their peers use the highest codes only 50% of the time. Once this is identified, an actual medical file review determines whether the physician actually did the higher level of service. "If this is not supported by the records, a recoupment would be sought. If the pattern was egregious enough, the provider could be referred on for a fraud investigation and possible criminal charges," says Mr. Trail.

Since the process is labor-intensive, resources have become an issue for many states. However, Mr. Trail said that as states have been fairly aggressive with fraud detection efforts over the years, "it's unlikely that the abuse is as great as some purport. The real issue is whether the detec-

tion technology and resources can be sufficiently improved to get at the remaining abuse in the system and accomplish the anticipated return on investment."

Sarah Lueck, a health policy analyst at the Center on Budget and Policy Priorities in Washington, DC, says the Payment Error Rate Measurement program, used by CMS to measure improper payments in Medicaid and the Children's Health Insurance Program, is at times mistakenly cited as fraud instead of errors. Another misconception is that fraud and abuse mainly involve beneficiaries deliberately misrepresenting their situation to try to get onto Medicaid. "That is just not the case, and there is no evidence that is going on. We are really talking about provider issues," says Ms. Lueck. "In particular, some of the biggest dollar recoveries that the federal government has been able to get have come from settlements with prescription drug makers."

Effective communication is key

Lisa Simonson Maiuro, MSPH, PhD, a consultant in the Sacramento, CA, office of Health Management Associates, says that one of the biggest challenges for Medicaid is effective communication between the audits and investigation field staff who get leads on fraud, and individuals who can use the Medicaid Management Information System/Decision Support System (MIS/DSS) to effectively mine the data and substantiate the fraud.

This observation is based on her position several years ago with a Medicaid MIS/DSS vendor. During that time, she oversaw a research group that addressed issues of fraud and abuse in the state Medicaid program, and she served as an expert witness to prosecute a provider who was defrauding Medicaid by using other provider IDs. After a tip was received, subsequent data analysis resulted in a successful case against that provider.

"While our unit had many algorithms to identify data outliers that may reflect fraud, there were a lot of false positives," says Dr. Maiuro. "Often, it was difficult to make a strong case from the data alone that there was fraud and abuse." For this reason, more effective detection and prosecution could occur through a stronger collaboration between field workers and Medicaid analysts.

Another major challenge is that of finding resources in an economically strained environment to detect and substantiate fraud or abuse. "While data analysis alone may not always be successful, it is an important component in the process," says Dr. Maiuro. "As many Medicaid programs face cutbacks, there are fewer resources available to keep up with the scam of the day and analyze data for patterns or irregularities that warrant further investigation. Even with ARRA [the American Recovery and Reinvestment Act], HIT funding state resources are so tight."

A November 2009 report, "The Fiscal Survey of States," from the National Governors Association and the National Association of State Budget Officers, both based in Washington, DC, forecasted continued fiscal difficulties for states. State revenues are expected to remain depressed throughout FY 2010 and likely into FY 2011 and FY 2012.

"Just this year, Medi-Cal terminated adult dental, a service it had offered for more than 40 years," says Dr. Maiuro. "With so many states facing budget problems that are likely to last well into the next decade, I'm guessing that simply providing services is going to be a struggle, much less focusing on fraud."

Patrick W. Finnerty, director of Virginia's Department of Medical Assistance Services (DMAS), says the department has worked with CMS and other national entities to have "a strong national Program Integrity presence."

"The department has consolidated its Program Integrity provider review resources across divisions," says Mr. Finnerty. The Program Integrity Division uses sophisticated data-mining software to identify providers whose billing practices appear aberrant in relation to their peers. An annual provider review plan assures that an appropriate number of providers is audited, and targets provider types which have the potential to be problematic based on certain risk factors.

"The plan is developed using national data and trends regarding provider types and risk assessments that are prone to inappropriate billing and integrity issues," says Mr. Finnerty.

More resources available

The health care reform discussion has addressed new efforts for fraud prevention and control in Medicaid and Medicare. "There are a few different ideas that have been incorporated in the various bills. One is an enhanced screening process for medical providers that are going to be billing the program," says Ms. Lueck. "There is definitely interest in trying to make sure federal programs are run as efficiently as possible."

As part of ARRA's Hi-Tech Act provisions, more resources are being made available to auditors and investigators. "Some of these efforts are new, and some are consolidations of previous efforts," says Dr. Maiuro. "All represent increased exposure for health care providers to additional audits and claims by the government for reimbursement of previous payments, or even claims of fraud or abuse. I have no sense about how successful these will be."

One example is a new CMS

program, Medicaid Integrity Contractors, which refers suspected fraud cases to the OIG for prosecution or sanctions. Other efforts include the Fraud Enforcement Act of 2009, and the Healthcare Fraud Prevention and Enforcement Action Team, a new interagency collaboration to combat Medicare and Medicaid fraud. "The initial plan called for the departments to expand Medicare Fraud Strike Force team operations currently operating in South Florida and Los Angeles to two additional metropolitan areas, Detroit and Houston," says Dr. Maiuro.

The Strike Force teams use a data-driven approach to identify unexplainable billing patterns and investigate the providers for possible fraudulent activity. "These will increase the use of on-site visits during provider and supplier enrollment, increase training and resources for providers on Medicare and Medicaid compliance, and improve data coordination between CMS and law enforcement to better identify patterns that lead to fraud," says Dr. Maiuro.

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Fiscal Fitness

(Continued from cover)

That is the longest sustained enrollment growth we have seen in more than eight years. September 2009 also marked the first time enrollment exceeded 2 million consumers."

Growth has been fairly steady over the past two years, including the holiday season, which is unusual for that time frame. "We are hoping that in about a year that the growth will begin to flatten. That's our hope, but I just don't know," says Ms. Burdette. "Actually, when we did our final budget estimate in April, we really ramped up what we expected the growth to be. And we added 17,000 consumers from May to June, and 22,000 from August to September."

Ms. Burdette says she expects the steep growth to moderate, but not level off completely for some time. "Since we are seeing most of the growth in our lowest income categories, we don't expect that the people coming on today, or at least their kids, will be coming off our program anytime soon. Because even if that family's income doubles, their kids will still be eligible for the program," says Ms. Burdette.

Normally, the state's budget would have been passed and signed into law by June 30, 2009, as the state's fiscal year starts in July. "But because of the challenges with increased spending and decreasing revenues, we didn't have a signed budget until mid-July. So, one of the things we are dealing with right now, only three months into the year, is having a short time frame to implement the changes we need to, in order to maintain a balanced budget," says Ms. Burdette.

Ohio Medicaid began seeing significant growth in July 2007, which necessitated some adjustments to plans. An expansion of the Children's Health Insurance (CHIP) program from 200% to 300% of FPL has been delayed while alternate funding sources are being identified. "Ohio has had a very interesting route with our CHIP expansion. It was originally approved for FY 2008 and 2009, and we planned to bring it up on January 2008. Then, CMS [the Centers for Medicare & Medicaid] came out with their Aug. 17 directive," says Ms. Burdette. "As Ohio is a Medicaid expansion state, our stance was the letter shouldn't even apply to us. But CMS decided to interpret their letter differently and apply it to us."

About a year later, approval was obtained for the expansion, now planned for March 2009. By that time, however, declining state revenues forced the expansion to again be put on hold; instead, it was built into the FY 2010 and FY 2011 budgets. Ultimately, the expansion was funded using tobacco funds. "We will also be shifting the funding for many our optional services for adults to tobacco funding, come February 2010," says Ms. Burdette. "Our hope is this way we won't have to reduce them. It was very important to the administration to be able to protect eligibility and protect services. We really are doing a lot of different things to find different ways to fund the program."

Protecting access

Ohio Medicaid was planning two community provider rate increases for 2009, but these never came to pass. Instead, provider rates are being reduced, along with pharmacy dispensing fees. In addition, a state-funded program for very low-income, childless adults was eliminated, a franchise fee for hospitals was added, and franchise fees were increased for nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR.)

"We are carving pharmacy out of managed care, so we can take advantage of rebates, as well as simplify things for consumers and providers. They will have one prior authorization and one Preferred Drug List plan to deal with, so we can reduce some confusion there," says Ms. Burdette.

A targeted provider rate increase of 3% on average became effective July 1, 2008. Now, as of Jan. 1, 2010, community providers will be given a 3% decrease. "We are not just undoing what we did. It will be a targeted increase," says Ms. Burdette. "But the point is, we put X dollars into the system, and now we are pulling that same amount out, a year and a half later."

Before the July 2008 increase, some providers had gone a decade without a rate increase. "So, while it was a small increase, relatively speaking, I think the provider groups would say it was long overdue," says Ms. Burdette. "Particularly with our community providers, when they see increases that our hospitals and nursing homes and ICFs-MR have had, it's been a bit of a bitter pill for them to swallow. That was why it was so important to bring them in, when we could, and talk to them about the best way of doing this."

One goal was to protect access to primary care or preventive services. "To do this, we looked less at provider type and more at codes," says Ms. Burdette. "We looked at codes that were at or near 100% of Medicare, and brought them back a little bit, to preserve savings for some of the other codes."

For dental services, provider groups were asked whether they preferred a rate reduction or decreased payments for services. "We really tried to look at the codes and prioritize them for what we thought was most important, with an incentive in the system for services that we thought needed to be provided," says Ms. Burdette. "For other areas, we thought about the uniqueness of how they do their business and what could we do to reduce the amount of money going into the system, but do it in a way that made sense. We are watching closely, but so far, we don't have any reason to believe there will be access issues."

"The big thing that we've really been focused on over the last few years is cost avoidance," says Ms. Burdette. In FY 2009, $704 million in commercial and Medicare insurance claims were cost-avoided, an increase of $83 million compared with 2008.

"We right now have over 85% of all the covered lives in Ohio in our system to be cost-avoided against. So, we have been very aggressive in using the ability that was granted in the DRA [Deficit Reduction Act], to bring that information in-house to allow us to cost-avoid," says Ms. Burdette. "That has been one of our biggest victories."

Significant cost savings also are expected from a new claims system being implemented. "Our biggest focus right now—from a budgetary perspective—in addition to just keeping our heads above water, is to bring up our new claims system," says Ms. Burdette. "We are very much in the midst of doing that. Our plan is to have it up by December of 2010. That will allow us to make some changes to be more efficient."

Better clinical claims editing will be possible. "While we have some claims edits in our system right now, this will allow us to do more complex edits," says Ms. Burdette. "We will be able to look at claims as they come in, the way they are bundled, and whether they make sense, and reject claims that should not go with each other. It's hard to get money back. It's always better to cost-avoid up front."

The new system also will make it easier to assess budgetary changes on benefit packages. "Right now, this is a huge undertaking. To select what's best for this population or that population is very complex to do," says Ms. Burdette. "This will allow us to make good changes more efficiently and really allow us to operate a better program."

Paper claim submissions will be eliminated, with all prior authorization requests received and responded to electronically. "So, we should really see a lot of efficiency there. We also plan to automate more of our phone system work and a lot of other calls that we do, which should be a great help," says Ms. Burdette.

Ms. Burdette says the end of federal stimulus funding is a definite concern. "But right now, we are doing what we need to do to get through FY 2010 and 2011. Some of that work is going to lower our costs, such as the pharmacy carve-out," she says. "That should put us in a better position going forward. What we are doing is laying the groundwork that will help us into 2011 and 2012, when the stimulus funding goes away."

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New data help Medicaid target high-need, high-cost populations

Cost-containment programs targeting high-need, high-cost Medicaid populations now have more information to work with. Researchers from the Hamilton, NJ-based Center for Health Care Strategies analyzed prescription drug use in addition to diagnostic claims in the October 2009 report, "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions." Here are key findings resulting from the addition of pharmacy data to the analysis:

• The percentage of Medicaid beneficiaries with disabilities and diagnosed with three or more chronic conditions increased from

35% to 45%.

• The prevalence of cardiovascular disease increased from 32% to 44%.

• Costs for Medicaid-only beneficiaries with three or more chronic conditions increased from 66% to 75% of total spending for beneficiaries with disabilities.

Pharmacy data were particularly valuable in illustrating the prevalence of psychiatric illness among high-cost Medicaid beneficiaries. The frequency of psychiatric illness among Medicaid beneficiaries with disabilities increased from 29% to 49%. Examining diagnostic and pharmacy data together, psychiatric illness is represented in three of the top five most common pairs of diseases among the highest-cost 5% of Medicaid-only beneficiaries with disabilities.

"The use of pharmacy data identifies many more beneficiaries with behavioral health problems than the use of diagnostic data alone," says **Richard Kronick**, PhD, one of the report's authors and chief of the division of health care sciences at the University of California—San Diego School of Medicine's Department of Family and Preventive Medicine. "This highlights the need for care management and quality improvement programs that are sensitive to the needs of beneficiaries with both behavioral health and physical health diagnoses."

Based on the study's findings, Dr. Kronick says state Medicaid programs should focus care management programs on beneficiaries with multiple comorbidities. "These beneficiaries account for a very large share of high-need, high-resource use beneficiaries," he says. "The disease management industry was established to take care of single diseases such as diabetes or congestive heart failure. But virtually all high-cost, high-need Medicaid beneficiaries have multiple comorbidities. A single-disease focus is not likely to meet their needs or reduce utilization and expenditures."

Focus of DM narrows

Washington Medicaid's approach to disease management has changed in recent years to focus more narrowly on high-cost, high-need beneficiaries. "Our state was an early adopter of disease management, but the program has changed considerably since 2002," says **MaryAnne Lindeblad**, Medicaid division director. "We have very much narrowed it down to target some of the highest-need populations, including populations with both physical and behavioral health issues."

Targeted reviews are being done of clients who are high users of narcotics. "These clients are often the ones who show up in ERs with drug-seeking behavior," says Ms. Lindeblad. "We are working with physicians to reduce narcotic utilization, get clients into pain management programs, and use other tools to manage chronic pain."

Another area of focus is determining whether Medicaid clients discharged from state mental hospitals are complying with their medications. "If folks are noncompliant with medications, they will often recycle and come back to the hospital," says Ms. Lindeblad. "So, we are trying to identify who those folks are, and what strategies we can implement to improve compliance with medications."

Switch to telephonic CM

Another change involved a switch from telephonic case management to making home visits to individuals, as with a pilot currently under way in Kings County. "For our first year in evaluating that program, we didn't see cost savings. But it didn't cost us anything more to have the program, so it was pretty much budget-neutral," says Ms. Lindeblad. "But we *did* see a statistically significant change in mortality."

This new approach will be expanded to other parts of the state, partly due to disappointing results from the telephonic model of disease management previously used.

"There certainly weren't any savings for the first couple of years. Maybe there was a little bit by the fourth year, but it didn't give us the kind of benefit or long-term changes that we were hoping to see in the population," says Ms. Lindeblad. "Research is supporting more on-the-ground intensive care management to help patients manage their disease. And we didn't see that happening with the telephonic approach."

The problem with Washington's previous disease management strategy, and some of the early efforts of Medicaid programs in general, was an underlying assumption that there would be near-term savings through these interventions, according to **Roger Gantz**, policy director for Washington Medicaid.

"The truth of the matter is, I don't think anybody saw that," says Mr. Gantz. "That isn't to say they don't do good things, but I think there has to be a note of caution. These savings don't always accrue in the near term. And unfortunately, we always operate on very narrow time horizons."

In addition, patients are typically not disease-specific, and in fact, have multiple care needs and disease states, including mental health issues. "The truth of the matter is, by the time they come into the Medicaid program, they already have chronic conditions. That is part of what qualifies them for the program. So, to be able to go upstream and do prevention is more challenging for the existing Medicaid program today, given who they are covering,"

says Mr. Gantz. "That is an aspect that sometimes gets lost regarding disease management strategies for a Medicaid-based population."

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PCCM programs can achieve cost savings, *if* significantly enhanced

A small but committed number of state Medicaid programs are setting out to enhance their primary care case management programs (PCCM) that link beneficiaries to primary care providers (PCPs) and pay providers for a core set of care management activities.

Some of the ways states are doing this include adding more intensive care management and care coordination for high-need beneficiaries; improved PCP incentives; and increased use of performance measures. A September 2009 report from the Hamilton, NJ-based Center for Health Care Strategies, "Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States," examined enhanced PCCM programs in Oklahoma, North Carolina, Pennsylvania, Indiana, and Arkansas.

"We actually had to do some fairly serious investigation of state PCCM programs to find the five programs that we highlighted in the paper. There were not a lot of other examples, at that point, of states that had devoted significant resources to enhancing their PCCM programs," says **James M. Verdier**, JD, lead author of the report and a senior fellow at Mathematica Policy Research in Washington, DC.

However, Mr. Verdier thinks there could be some growing interest in states operating their own PCCM programs either with state staff or contractors who would administer various aspects of the programs, but they would not be at risk for services in the way a full risk-managed care organization would be.

"States have a variety of motives for wanting to do that," says Mr. Verdier. There may be dissatisfaction with the managed programs currently operating in the state, there might be a lack of interest among managed care organizations in participating in the Medicaid program, or it may be difficult to run fully capitated managed care programs in certain areas of the state.

"Sometimes states want a PCCM program as a form of competition for the managed care organizations, or as a fallback alternative if they conclude that their experience with the full risk-managed care organization is not turning out to be satisfactory," says Mr. Verdier.

ROI difficult to measure

"You can't just pay doctors $3 per member per month and expect them to do very much in the way of care coordination or case management," says Mr. Verdier. "And that's especially the case when you are talking about part of the Medicaid program that involves people with disabilities and chronic illnesses."

These individuals have very complex and substantial health care needs that are often outside the capability of an individual doctor, or even a small group of physicians with limited time and resources. "To do that effectively, you need the kind of care coordinators and nurse care managers that Oklahoma and a number of other programs have," says Mr. Verdier.

A substantial amount of resources are needed to provide the necessary level of care coordination and care management, especially for the aged/blind/disabled and Supplemental Security Income populations. "If you're talking about just moms and kids, the PCCM model works pretty well for them, taking care of basic care needs. But we didn't really look at states that were doing just that, because it didn't really require much in the way of program enhancements," says Mr. Verdier.

It's difficult for PCCM programs to save a substantial amount of money keeping people out of hospitals and EDs. One reason is that the doctors are not at financial risk for hospital use, and they don't necessarily have the contractual relationships or leverage over hospitals needed to either reduce admissions or keep a discharged patient from going back into the hospital.

"If you look at the Medicare-coordinated care demonstrations, the ones that were successful really devoted a lot of resources to keep people from being rehospitalized," says Mr. Verdier. "Virtually none of the enhanced PCCM programs that we looked at really had the capability of doing those kinds of things." Therefore, programs aren't getting the kind of savings from reduced hospital use that might be needed to fund substantial enhancements.

"Now, if you are running a PCCM program that doesn't have a lot of enhancements and is not incurring a lot of costs, then the program can be cost effective for the state," says Mr. Verdier. "That is true even if it doesn't have a major impact on expensive services like hospitalization, because it's not incurring major costs."

This is because even a bare-bones PCCM program will provide some benefit to beneficiaries. "It's always good to be linked to a primary care

physician and to have that physician be your link to appropriate specialist care. So, even a PCCM with mild enhancements is going to add some value to beneficiaries," says Mr. Verdier. "But it's a separate question whether they save enough money to pay for themselves."

Return on investment is difficult to compute, based on the experience of the five states in measuring their cost savings. "We tried to look at cost issues in the paper. The conclusion I came away with is that these estimates are really hard to do," says Mr. Verdier. "This kind of estimating is expensive to do well and takes a fair amount of time to come up with any conclusions. Also, you need fairly large groups. Otherwise, you don't get statistically reliable results."

Savings require resources

To get dramatic savings, PCCM programs must have a strong focus on avoiding hospitalizations and providing people with support as they leave hospitals. "The bottom line is that in the absence of those kinds of features, it's hard to achieve major savings," says Mr. Verdier. "It's not that difficult to have a valuable impact on the quality of care for enrollees at a relatively modest cost. But it's difficult to produce actual budget savings from doing those kinds of things. You may be providing better care and running a better program, but you are not necessarily saving a huge amount of money."

Low-cost changes include providing physicians with real-time information on prescription and emergency department use by their patients. "With Medicaid sharing claims for that kind of service use with physicians, situations may be identified where the beneficiary is getting drugs from more than one physician, which the physician would typically not know about," says Mr. Verdier. It would be more difficult for Medicaid to provide physicians with real-time information about patients going into hospitals, since the Medicaid agency doesn't know about this until the hospital submits the claim, oftentimes several months later.

"But in theory, Medicaid could require the hospital to inform the PCCM agency, who in turn could inform the physician when such an admission occurs," says Mr. Verdier. "That wouldn't require a lot of resources."

Medicaid programs also can send physicians comparisons of their own service use against statewide averages. "They can see where they compare with their colleagues and areas where they might improve," says Mr. Verdier. "That is another useful, fairly low-cost enhancement, which states are doing to good effect."

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Oklahoma Medicaid reports on recent changes to its PCCM program

Oklahoma's Medicaid director, **Lynn Mitchell**, MD, says as of January 2009, the state's primary care case management (PCCM) program, called SoonerCare Choice, in which 423,000 Oklahomans participate, had "further embraced the patient-centered medical home principle, and we did that as a request from our providers. We feel that this will take even a further benefit to our members."

About two years ago, a group of physicians on the state's Medical Advisory Task Force asked that some changes be made to the PCCM program. "We listen when our providers speak. We take that very seriously, to make sure we don't lose sight of the fact that our providers are on the ground, providing services to our 660,000 members," says Dr. Mitchell. "And a lot of our providers were telling us if we can move toward a delivery model consistent with a patient-centered medical home, that's why they went to medical school. They want to be able to serve patients in that kind of a delivery model."

The providers wanted Medicaid to do away with its auto assignment process, eliminate partial capitation payments, and enhance care management and fee-for-service payments. All of these changes were made, and the program was supplemented with a pay-for-excellence program.

"We took the program that was currently in place, and we made some changes in how we pay our providers around certain quality indicators that we wanted to incentivize," says Dr. Mitchell. Providers can now self-assess their ability to be a medical home for members.

These changes were budget-neutral. "We took the dollars that were currently being expended in the program. We reconfigured some of those, and incentivized new and different things," says Dr. Mitchell. "While we are early in the program, at this point it is certainly showing to be budget-neutral and will perhaps eventually show us some mild savings."

Initially, there was a concern that SoonerCare might lose some of its primary care providers because of the change to a new payment model. "We monitored this very closely, while working to educate our providers. And we listened to providers and made some changes that they were in the driver's seat for," says Dr. Mitchell. "When the program was up and running, we actually lost less than 10 of our 850 providers. And since that time, around 70 new providers were added."

One area of focus for future improvement involves interagency collaboration and coordination. "That is an area we did OK in—but could always do better with," says Dr. Mitchell. "We found it very helpful to collaborate across health agencies, and I think sometimes we miss that opportunity."

Input from other agencies was incorporated into the new delivery model. For example, a suggestion that providers screen for mental health and substance abuse was included in the outcomes measures and assessment for the ability to be a medical home.

Dr. Mitchell says one key is "enhancement of the infrastructure that is needed to wrap around our primary care providers, to allow them to be a medical home. This involves things like HIT services and care management that the providers need to have available to them to offer that level of care to the members."

Toward this end, Oklahoma is in the process of implementing its health access network. "This represents a tool that we can utilize to better meet the needs of our members and our providers," says Dr. Mitchell. "All of the network's services wouldn't be needed on a routine basis, but if a particular need arises, they would have somebody they could call to help them obtain that service on behalf of the member."

A growing number of states are implementing medical home initiatives across multiple payers, not just the Medicaid program. "Some states are moving to an all-payer model, to get a consensus among insurance companies and other payers in the state that this would be a model that would behoove all of the state citizens," says Dr. Mitchell.

Transition was smooth

Rebecca Pasternik-Ikard, RN, JD, state Medicaid chief operating officer for the Oklahoma Health Care Authority, says that medical homes are particularly important at a time when Medicaid populations are growing and budgets are shrinking.

"When members are aligned with a primary care provider of their choice, they are given access to care with a provider who knows their needs and health history," says Ms. Pasternik-Ikard.

Oklahoma Medicaid's switch to the patient-centered medical home model has cut down on inappropriate use of ED services, because members are directed to the most effective source of care when they need it. "We also know that reimbursement must be equitable if we are to recruit and retain providers throughout the state to serve our members," says Ms. Pasternik-Ikard. "We can provide more care to more people if our funds are used effectively."

SoonerCare Choice is approaching the end of its first year using the new patient-centered medical home model. "The transition was relatively easy, for two reasons," says Ms. Pasternik-Ikard. First, Oklahoma ended all of its HMO contracts as of Dec. 31, 2003, and moved all of the HMO members into the state's managed care option, SoonerCare Choice. As a result, members already were familiar with the primary care provider/medical home concept, and providers were comfortable with the mechanics of the program.

Secondly, SoonerCare Choice providers and members were prepared throughout 2008 for the transition. "One of the core recommendations from the task force was to completely eliminate auto-assignment, which we implemented," says Ms. Pasternik-Ikard. "We also added many other elements as we solicited and received new ideas from providers across the state."

New payment structure

The changes were largely invisible to members, but they had a palpable impact on providers. The previous partially capitated plan was replaced with a new payment structure including care coordination, a visit-based fee-for-service component, and payments for excellence.

The care coordination payment is based on each practice's capabilities and the member populations served. "We felt the new structure would rectify some perceived inequities in the previous plan that paid providers a bundled monthly fee for their entire panel of SoonerCare members, regardless of whether they were seen," says Ms. Pasternik-Ikard. "The new plan offers providers higher reimbursement for patients who require considerably more time and attention."

Because some providers were concerned about the effect on their income, a decision was made to offer them transitional payments for the first year to provide cash flow support during the early transition period. After six months, only 16% of providers still required assistance.

Oklahoma's new payment structure places providers in one of three medical home tiers: entry level, advanced, and optimal. This tiered, performance-based component allows providers to draw a higher per-member-per-month rate by providing additional services, such as using e-prescribing, adopting evidence-based guidelines on preventive and chronic care, and adopting a more flexible scheduling process.

Providers also will receive quarterly "payments for excellence" for child health exams, generic drug prescribing, screening for breast and cervical cancer, visits to patients in the hospital, and participation in a

project to reduce inappropriate ER utilization. "We believe the financial incentives will result in improved access and care for members," says Ms. Pasternik-Ikard.

When the first quarterly payments were made in May 2009, 87% of providers received a payment. "Member calls related to access to care have declined," reports Ms. Pasternik-Ikard. "Our patient advice line and our SoonerCare Helpline now offer members who cannot schedule visits during normal office hours information about providers who do offer after-hours care."

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Equal footing needed with community-based services for LTC

When **Michael P. Starkowski**, commissioner of Connecticut's Department of Social Services, gave a recent presentation, a woman in a wheelchair approached him during a coffee break. She asked whether he had anything to do with Money Follows the Person (MFP), a Medicaid initiative that helps people transition from institutions to community living. "I said yes, very much so. It's one of the things we really believe in and have promoted," he says. "And she told me, 'I was in a skilled nursing facility for 11 years and moved out a month ago. You wouldn't believe what it's done for me.'"

Mr. Starkowski says that a success story like this flew in the face of some of the original expectations for MFP. "You have to be in a minimum of six months, so I thought we would catch all these people who'd been in there seven or eight months. You really didn't think you were going to be able to move somebody out that's been in a nursing facility for a long time, because their community support is gone, their assets and furniture are gone," he says. "But here's a person who had a disability, had been there for 11 years, went back into the community, and just feels it was the best thing we could have done for them."

Since January 2009, Connecticut has transitioned about 100 people out of 54 different skilled nursing facilities. MFP, part of a federal Medicaid "rebalancing" initiative that offers enhanced reimbursement for more cost-effective care, is the latest in Connecticut's programs that offer community-based alternatives for people who do not need institutional care with sufficient support services in place. "We have seen a significant savings as we help people get back into the community," reports Mr. Starkowski.

The goal is to move out about 700 people by 2011. "I think the program is catching a lot of steam right now. There is a pent-up demand of people trying to move back into the community if we can provide support for them," says Mr. Starkowski.

Finding adequate support is a major challenge, however. Connecticut's Gov. M. Jodi Rell, who authorized the MFP program, announced an initiative that will utilize stimulus funding for scholarships and other incentives to encourage individuals to go into the nursing profession.

"It will take time for that to come to fruition, in order to have adequate networks out there. Meanwhile, we have a shortage of nurses and health care workers, like everybody else is experiencing," says Mr. Starkowski. "We do have some people going into our personal care assistance program, which is a waiver program funded through Medicaid, but that's a handful of people."

Equal footing is needed

Laura Summer, author of the Washington, DC-based Kaiser Commission on Medicaid and the Uninsured (KCMU)'s September 2009 report "Efforts in States to Promote Medicaid Community-Based Services and Supports," and a senior research scholar at Georgetown University Health Policy Institute, also in Washington, DC, says one problem is that community-based and institutional long-term services are not on equal footing. "We need a more level playing field, I think, for the two types of services," says Ms. Summer.

Home and community-based services (HCBS) waivers have been the primary means of expanding community-based services, but the waiver process is cumbersome. Also, some states have more restrictive financial eligibility criteria for HCBS than for institutional services.

Applicants who wish to remain in the community also face significant challenges if the Medicaid eligibility determination is not done quickly. They may not be able to arrange for home modifications or for services they need while they are waiting for assurance that the services will be covered. Traditionally, institutional providers have been more willing to provide services before an individual is determined eligible for Medicaid.

Financial and functional eligibility determinations, assessment procedures, and the mix of available community-based services for individuals with disabilities may differ within and across states. "States that have established a single administrative agency, use a uniform assessment process, or use global budgeting for the provision of all

types of long-term services and supports have been leaders in promoting community-based services," notes Ms. Summer.

Impact of recession

States in dire financial straits may not be able to do major redesigns of their long-term care programs. "On the other hand, in the past, states have looked at tough economic times as the impetus for innovation," says Ms. Summer. "I think that states are going to have to pay a great deal of attention to how they provide long-term care."

Most states already have coverage limits, enrollment caps, and waiting lists for community-based services. Two states in FY 2009 and seven states in FY 2010 imposed additional restrictions directed at HCBS programs, according to the September 2009 KCMU report, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession." Although the majority of states still are taking action to expand and improve access to Medicaid HCBS, the KMCU report found that only 32 states are adopting these policies in FY 2009, compared to 42 in FY 2008.

"The bottom line is that states *are* continuing to work on reorienting their Medicaid long-term care delivery systems towards more community-based services. But in these times of fiscal stress, most states are focused on maintaining current levels of service for those already enrolled in the program," says **Molly O'Malley**, a senior policy analyst with the Henry J. Kaiser Family Foundation in Menlo Park, CA.

Going forward, states will be faced with the added challenge of the expiration of the American Recovery and Reinvestment Act (ARRA) funds. "That could force many states to make additional cuts to Medicaid eligibility and benefits, including potential reductions to HCBS," says Ms. O'Malley.

Jennifer Burnett, deputy secretary for the Pennsylvania Department of Public Welfare's Office of Long Term Living, says that since taking office in 2003, the state's governor has made long-term care reform a priority. "A critical element of the strategy was establishing a single point of accountability for the continuum of long-term care," says Ms. Burnett.

In 2007, the Office of Long-Term Living was established, as a joint office of the Department of Aging and Department of Public Welfare. The office is responsible for the management of eight home and community-based waivers serving the elderly and younger people with physical disabilities, the state-funded OPTIONS program for seniors, the Act 150 program of attendant care for people with disabilities, the LIFE PACE (Living Independence for the Elderly/Program of All-Inclusive Care for the Elderly), senior centers, adult day programs, domiciliary care, and Pennsylvania's Medical Assistance nursing facility payments.

"We have worked hard to rebalance the state's reliance on nursing facility care in the past two years, by shifting long-term care utilization," says Ms. Burnett. "The percentage of total long-term care recipients now receiving services in HCBS has increased nearly 6% in two years."

The number of adult day services centers has grown from 239 in 2006 to 256 today, and LIFE PACE centers, which numbered just four in 2003, will grow to 19 by 2010. "A renewed commitment to senior centers is an important component of the long-term care system, with a critical role in prevention," says Ms. Burnett.

A rapid assessment process is used in a Community Choice pilot program currently under way in 12 counties. Eligibility for services in the community is expedited using shortened forms, and post-verification of income and assets. This effort involved the Office of Income Maintenance, the office responsible for eligibility for Medicaid.

"It allows individuals to self-declare their assets and income, while the lengthy process of verifying eligibility occurs after the person begins receiving services," says Ms. Burnett. "We are in the process of evaluating the outcomes and will make decisions about rolling this out statewide once the review of the pilot is completed."

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Industrial hygiene group says N95s the right call

The American Industrial Hygiene Association (AIHA) has issued a position statement on H1N1 pandemic influenza A that endorses and reiterates the key findings of an Institute of Medicine panel that recommended N95 respirators for health care workers. Key points stressed by AIHA include:

• H1N1 and seasonal influenza are spread by the airborne route and not limited to "droplet" or contact spread.

• A current H1N1 infectious dose has not been established. This could vary for every organism, disease, and microbial strain; therefore, it is not effective to stratify protective measures.

• Health care workers are at increased risk of H1N1 infections. Health care organizations and workers need consistent and clear H1N1 guidelines that can be implemented across all health care facilities. In addition, employers must devote significant effort to assessing risk in their organizations and to fully implement those guidelines so needed practices are widely adopted. This should include ongoing education and training of health care workers.

• Respiratory protection is one component of an effective aerosolized transmissible disease program. Other components include appropriate administrative and engineering controls (i.e., triage, cohorting of patients, prompt identification, isolation, signage, patient masking in public or semipublic areas, covering cough and sneezes, hygienic practices, education, ventilation).

• Health care workers (including those in nonhospital settings) who are in close contact with individuals with H1N1 influenza or influenza-like illnesses should be provided with fit-tested N95 respirators or other respirators that are demonstrably more effective. This is one measure in the continuum of safety and infection control efforts to reduce the risk of infection. Employers should ensure the use and fit testing of N95 respirators be conducted in accordance with OSHA regulations, and health care workers should use the equipment as required by regulations and employer policies. An effective respiratory protection program must include medical surveillance, fit testing, and training as described in the NIOSH and OSHA documents and standards.

• Adequate respiratory protection is not provided by "surgical masks," including most devices approved by the Food and Drug Administration. ■