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More cuts coming for Medicaid? Utilization management can't be ignored

Medicaid programs may never have had as much reason to redouble their utilization review efforts, in order to be sure funds are not being spent inappropriately, as they do right now.

Fourteen states reversed planned restrictions to Medicaid eligibility, and five states abandoned plans to do this, in order to qualify for enhanced Federal Medical Assistance Percentages (FMAP) through the American Recovery and Reinvestment Act (ARRA), according to a September 2009 report from the Kaiser Commission on Medicaid and the Uninsured.

The funding also allowed many Medicaid programs to maintain optional services and avoid drastic provider rate cuts.

The ability to avoid devastating cuts may have been short-lived, however. Some Medicaid programs are now contending with another round of budget cuts, due to declining revenues. Another looming threat on the horizon is the loss of the enhanced FMAP dollars on Dec. 31, 2010.

"Every dollar counts, and utilization management is one approach that has long-lasting impacts," says **Leslie Clement**, Idaho's Medicaid

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Washington Medicaid facing additional cuts: What's next for recipients?

After last year's round of budget cuts, Washington Medicaid seemingly exhausted all opportunities to achieve savings through purchasing initiatives. Now, the program faces another round of budget cuts, threatening its progressive state-only programs and possible benefit reductions to its Medicaid program. To what extent will the state's successful cost-containment programs mitigate this dire situation? That remains to be seen.

Fiscal Fitness: How States Cope

"Like many, if not all, states, we are experiencing a historic increase in eligibility," says **Roger Gantz**, policy director for Washington Medicaid. "That is happening in three areas that we would have anticipated, and another area where we are not quite sure what it means."

In recent years, caseloads for families covered by the state's Temporary Assistance for Needy Families (TANF), or those who qualify for TANF but elect to get Medicaid coverage, has drifted downward slightly. About six months ago, though, the caseload began increasing sharply, a trend that is expected to continue at least

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Medicaid cuts

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administrator. "While it can't be 'the' solution, it helps with long-term sustainability."

Clement says Idaho's revenues continue to fall short of needed funding, while enrollment increased 4% in state fiscal year 2009. There is a projected caseload increase of 8% in the current 2010 year. "Expenditures continue to increase. The gap is anticipated to be especially significant in state fiscal year 2011, when the increased FMAP drops," says Ms. Clement. "There is no way to mitigate the potential impact. We need to assume that the FMAP will go away because of when our legislature is in session."

The impact to Idaho Medicaid, says Ms. Clement, "will be devastating, with costs increasing, caseload increasing, FMAP decreasing, and state revenues in decline. We have no good policy options for quickly reducing our costs to balance the budget. But we will be forced to make those decisions."

Pricing reductions for hospitals and nursing homes, pricing freezes for providers, and reductions in optional benefits for behavioral health and developmental disability services have all already been done. "We also implemented some utilization management approaches," says Ms. Clement. "More of these will be implemented for the current FY 2010 year."

These new approaches included a transportation brokerage system, adding all Medicaid participants into an outsourced dental plan, and implementing utilization management for diagnostic imaging. "These management strategies are expected to realize $10 million in annualized savings," says Ms. Clement. "These strategies will be added to existing hospital utilization management and case management, which have realized an average return on investment of $5.04." That translates into a total net savings of about $3.7 million.

Additional savings have come from Idaho's pharmacy management program, which assures that only medically necessary prescriptions at the least cost are authorized.

One promising development is that new systems can now identify practice patterns that don't conform to evidence-based standards or that aren't being utilized appropriately. "We are looking forward to implementing a new MMIS system in 2011, which will provide additional system edits and audits," says Ms. Clement. "Utilization management can be effective for containing costs over the long term. But without the right technology, it can be very labor-intensive."

Low-hanging fruit already picked

Heather Burdette, MBA, assistant deputy director of Ohio Health Plans, says, "After years of coming up with increasingly creative ways to save money, we have taken all the low-hanging fruit. Now, we are at the point of taking advantage of those which are more difficult to implement and/or have a lower return on investment."

Ohio Medicaid's caseload increased by about 170,000, or 9%, in the past 12 months. "This is the largest caseload growth during a 12-month period in more than seven years," says Ms. Burdette. Ohio Medicaid has made these changes in utilization management:

—A study on Durable Medical Equipment utilization is currently being completed.

"This will inform policy changes which might be able to increase our efficiency in this area of our business," says Ms. Burdette.

—An effort is being made to reduce inappropriate use of advanced diagnostic imaging services, such as magnetic resonance imaging.

Ohio's 2010/2011 biennium budget states that "Not later than Jan. 1, 2010, the Department of Job and Family Services shall implement evidence-based, best practice guidelines or protocols and decision support tools for advanced diagnostic imaging services available under the fee-for-service component of the Medicaid program." "To that end, we are finalizing our proposals to meet this requirement," says Ms. Burdette. "Once we complete our research and settle on an approach, we'll be able to provide an assessment of the impact."

—Custom wheelchairs, transportation, oxygen, therapies, and over-the-counter drugs were bundled into nursing facility rates.

"This will align incentives for nursing facilities to utilize the most efficient means to provide quality health care to their residents," says Ms. Burdette.

For instance, a nursing facility might previously have scheduled an ambulette to transport a resident to a doctor's appointment. "Today, they might find it more efficient to use their own adequate transportation resources and coordinate office visits to save money and reduce the number of trips," says Ms. Burdette.

—Pharmacy is being carved out of managed care.

This is being done to allow consumers, providers, and pharmacists to have one formulary to work with, with consistent prior authorization requirements for consumers.

"To help ensure utilization does not increase unnecessarily, we have structured the managed care capitation rates to align their incentives around utilization management with our goals," says Ms. Burdette. "We have also worked closely with the plans to ensure they have the tools necessary to make the transition seamless, so they will be our partners in this as we move forward."

Approach has limits

One obvious limitation of utilization management efforts, however, is that most of these occur when patients are *already* in the hospital, instead of preventing them from getting there in the first place.

"There isn't enough being done to ensure they do not get rehospitalized, and there is much to be saved there," says **Anne Gauthier**, a senior fellow at the Washington, DC-based National Academy for State Health Policy. "The emphasis is on the expensive cases, but the best approach is a full chronic care model. That can reap the most savings."

There is no question that utilization review is important for Medicaid programs. "That needs to be done, but it isn't going to get at the biggest issues. It won't really improve the delivery system to improve care with care of patients with chronic illnesses," says Ms. Gauthier. "Broader payment reform is another new approach, but there aren't many states really thinking about that right now."

The most innovation is coming out of programs aiming to strengthen primary care, sometimes through medical homes, says Ms. Gauthier. "They are trying to connect practices in ways that provide a better system for patients, so that in some cases, they avoid hospitalization altogether. And if they *are* hospitalized, there is appropriately coordinated support when they leave, so they take their medications, which is a leading cause of readmission. And they are seen by a physician quickly if necessary, so they don't wind up back in the hospital again."

These kinds of initiatives, combined with the use of electronic medical records and health information exchanges, can help identify the patients at most risk of being hospitalized. "These patients need continuing management of their chronic disease. Paying attention to those patients is the opportunity for the biggest savings," says Ms. Gauthier.

Another potential missed opportunity for state Medicaid programs involves savings achieved through health information technology (HIT). These would likely be much more significant if HIT planning efforts were tied to utilization review approaches.

"Most states are planning on investing in HIT, but that planning is happening outside of folks doing utilization review," says Ms. Gauthier. "It's actually possible that Medicaid programs could see a return on investment in their HIT investments, if they implemented electronic medical records and Health Information Exchanges in *conjunction* with their systems for looking at utilization review. But as far as I can see, most are in two very separate tracks."

Making upgrades to existing MMIS systems, says Ms. Gauthier, "is taking over all the airspace. Most states have extremely clunky and old systems. So, just to get them into the modern age is taking all their efforts."

Clearly, no one wants Medicaid dollars to pay for inappropriate or unnecessary care, but there is also the big picture to consider, says Ms. Gauthier. "Recovering money fraudulently spent is important to do, though it's not the major driver of costs," she says. "It is true that sometimes millions of dollars are recovered. But that pales in comparison to the billions of dollars that could be saved if incentives were better aligned in our system. Providers

could keep somebody out of the hospital and not be financially penalized for doing so."

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Fiscal Fitness

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through June 2011.

The other area that has seen a major increase in enrollment is coverage for children. Two years ago, Washington implemented the Apple Health For Kids program, a commitment to provide affordable coverage for all children in the state. As part of this initiative, Children's Health Insurance Program (CHIP) coverage was increased from 250% to 350% of FPL. "Also, Apple Health is available to both citizen and noncitizen kids. Our legislature made a commitment that kids are kids, and we're going to provide health coverage for *all* children," says Mr. Gantz.

The Apple Health program continues to grow quickly, more than anticipated. "The rate of increase was a little surprising to us," says Mr. Gantz. "It reflects the deterioration in the economy, loss of access to employer-sponsored coverage, and the lack of affordability of group markets in the state. It is a challenging dilemma."

If caseloads continue to increase at the current rate, by 2011, the Apple Health program would cover about 46% of all children in the state. "What Medicare is to seniors, Apple Health will be for children," says Mr. Gantz.

The other two areas of growth are Medicaid coverage for the elderly and people with disabilities. "Beginning in late 2008, we began to experience an increase in growth rates for Medicaid coverage for the elderly," says Mr. Gantz. "This increase in growth rates is not yet tied to the anticipated increase due to the baby boomers. It also appears to be for persons in the 65-69 age range, which may be tied to the economy as younger, low-income elderly lose employment."

Washington is experiencing a significant growth rate in Medicaid coverage for persons with disabilities. "We believe this is also attributable to the recession and to efforts on the part of the Social Security Administration to expedite the SSI and SSDI application and approval process," says Mr. Gantz.

All of these populations are "very high cost," adds Mr. Gantz. "And this is coupled with a significant dampening in our revenue base in our state. Again, this is not unique to Washington, but it is certainly going to be very impactful."

Pressure on safety net

The possibility of inadequate capacity for Medicaid clients is a definite concern. "The increased number of enrollees is putting a lot of pressure on our system from a capacity perspective, including our providers and the safety net system," says **MaryAnne Lindeblad**, Medicaid division director.

Back in 2007, some significant rate increases were given to primary care providers for children, followed by a smaller increase for adults. Most of those increases were rolled back in July 2009. "We are still looking at what effect that had, in terms of maintaining provider capacity," says Ms. Lindeblad. "But certainly, it was a significant hit to our program. Anecdotally, we have heard of providers who a year ago were willing to open their doors to Medicaid kids but are now back to limiting the numbers of kids or only seeing them through a managed care plan."

A total of $9 billion was cut from state services in the 2009-2011 biennial budget. This resulted in a major reduction in the state's Basic Health program, a state-sponsored program providing low-cost health care coverage through private health plans. The reduction will decrease Basic Health enrollment from about 104,000 to 65,000 individuals.

Since then, Gov. Chris Gregoire announced a supplemental budget proposal to address another $2.6 billion deficit in state revenue. Under the proposal, the Basic Health program would be eliminated effective June 30, 2010, which would save the state $160 million. Other programs targeted for elimination are Apple Health for children, which provides health care coverage to 16,000 low-income children and costs $11 million, and the General Assistance Unemployable program, which provides cash grants for 35,000 adults and medical services to nearly 17,000 adults at a cost of $188 million.

The new $2.6 billion deficit, says Mr. Gantz, "is coming at a time when we have already made a variety of other cuts. For the most part, we were able to avoid not having to reduce coverage for individuals or benefits. Most of the cuts were around what we called purchasing opportunities. But we have exhausted most of those opportunities."

The first round of cuts is expected to reduce the number of individuals covered under Basic Health to about 60% of the current number. "And this next round of cuts could result in complete elimination of the program," says Mr. Gantz.

Due to the ARRA's Maintenance of Effort requirements, states like Washington, which have been progressive in coverage for non-Medicaid populations, may be forced to reduce or eliminate those programs. "And in turn, that puts pressure on the safety net system, in terms of their capacity to respond to that need," says Ms. Lindeblad. "Because if, in fact, these programs are eliminated, that would increase the uninsured rate overnight by about 100,000 families."

A number of these individuals have been receiving their medical care and their medical home through their FQHC [Federally Qualified Health Center] system," says Mr. Gantz. "If the Basic Health and General Assistance medical programs go away, it's the same individual, with the same demands on services, and the same provider community. Now, these people are uninsured."

The state recently went through a revamping of the way FQHCs and rural health clinic providers are reimbursed. "Part of it was as a result of how we were paying the providers in the past. We have moved to an alternative payment system that will serve our safety net providers better than our older system in the long run," says Mr. Gantz. "We did this as an acknowledgement of the critical role they play, not only for our Medicaid program, but for our low-income community in general."

Since many of the cuts so far involved state-only programs, the number of services available for people not eligible for Medicaid is getting "narrower and narrower," says Ms. Lindeblad. "And as we are facing some additional cuts, these may be eliminated almost in their entirety. That is a public safety issue. There are a variety of other problems related to that." For instance, the situation also affects the infrastructure of county governments, in terms of their capacity to provide services to indigent individuals and those without insurance.

Long-range vision

With national health reform on the horizon, and the possible expansion of Medicaid to 133% or 150% of the FPL, Mr. Gantz says it would be possible to provide health insurance coverage including behavioral health, to individuals who did not have it in the past. "The challenge, though, is that we could see a drawing back of coverage and the delivery system now, then in [a] couple of years, turning around for a major ramp-up," he says.

Currently, Washington Medicaid is placing a lot of hope on person-centered medical homes as a long-term cost-containment strategy. A multipayer approach will be used, including most of the health plans in the state, and the health care authority that runs the Basic Health plan. "We are looking at coming up with some different payment strategies and payment reform initiatives, to advance that concept across the whole state," says Ms. Lindeblad. "We are looking at how we can really revamp and revitalize the primary care delivery system."

Unfortunately, the state's current fiscal situation may slow this progress. "There is no new money, so we are looking at doing major system reforms, such as doing a better job of managing chronic disease, with existing resources. And frankly, with declining resources," says Ms. Lindeblad.

Another approach involves targeted copayments. These are viewed not as a strategy to share the cost of coverage, as with coinsurance or deductibles, but rather, as a way to influence people's behavior patterns. "Copayment and coinsurance strategies work, but the problem is that they don't discriminate well," says Mr. Gantz. "With a low-income population, the strategy is to use them in very carefully targeted areas." For example, copayments are never put on anything that is related to prevention or primary care. Instead, these are used to promote generics or preferred drugs and to reduce avoidable emergency department use.

Already, there is evidence that targeted copayments are effective. Since the Basic Health plan requires that a family is under 200% of FPL to enroll, families on the program are similar demographically to Medicaid families. However, their ER utilization is significantly lower. "Basic Health has a copayment on ER use and Medicaid does not," says Ms. Lindeblad. "You have to find the right incentives. That is a good example of where a copay strategy seems to have worked."

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Budgetary challenges may limit ability to recoup Medicaid overpayments

In fiscal year 2008, Alabama's Program Integrity Division's Pharmacy Audit unit reviewed 143 medical providers and 629 pharmacies to assure proper claim payment and recovery of identified overpayments. This resulted in about $4.7 million in medical provider recoupments and $429,422 in pharmacy recoupments. In FY 2009, $332,000 was recovered for the state due to three hospitals' overbilling for a chemotherapy drug.

"We have always been very aggressive on this front," says Alabama Medicaid Commissioner **Carol H. Steckel**, chair of the Washington, DC-based National

Association of State Medicaid Directors. "Maximizing all available taxpayer dollars for the benefit of Alabama Medicaid recipients is an ongoing priority for the agency."

System edits and program efforts have been designed to prevent inappropriate payments *before* these are made. For example, prior authorization programs head off problems prospectively, while ensuring that recipients get medically necessary care or medications.

"We also have some other program initiatives that contribute to the overall efficiency of our program while preventing overuse or misuse of Medicaid dollars," says Ms. Steckel. "Our radiology management effort has saved a considerable amount of money in a very short time."

Ms. Steckel expects that Health Information Technology (HIT) will help the Medicaid program's utilization review efforts. One reason is that it will give more complete information about recipients. "This not only sets the stage to improve the quality of care provided to our recipients. It hopefully will also expand our capabilities to identify patients and providers who abuse or misuse the system," she says.

The Recipient Review unit, which investigates recipients who appear to have abused or misused Medicaid benefits, conducted 2,487 reviews in FY 2008. This resulted in 635 recipients being restricted or "locked-in" to one doctor and one drug store, with a cost-avoidance benefit to the agency of $344,459.

The quality control unit reviews eligibility determinations for accuracy to ensure that only eligible individuals qualify for Medicaid. "Alabama's Quality Control rate is consistently below the national rate of 3%, most recently 0.5101 for the October 2007 to March 2008 period," reports Ms. Steckel. Here are other utilization review measures that have had good results for Alabama Medicaid:

—New applications of durable medical equipment providers are reviewed prior to enrollment, to ensure they have a legitimate office and office staff;

—All provider applications are reviewed that indicate any kind of disclosure information before giving approval for enrollment;

—The list of sanctioned individuals is reviewed to ensure they are not working in any capacity for an entity that receives payments from Medicaid or Medicare;

—There is a requirement that any recipient who has eligibility reinstated after being suspended from the Medicaid program for drug-related fraud, abuse, or misuse of benefits is placed in the restriction program. Their utilization of benefits is monitored for one year.

In addition to the efforts of the Program Integrity Division, numerous system edits and program oversight measures are in place to ensure that prescribing providers hold a valid license, and providers who are deceased or who have moved from the state are removed.

"Edits are also placed in the system for providers who have been suspended from Medicare or Medicaid to ensure that any claim does not go through," says Ms. Steckel. "Provider representatives from HP Enterprise Services, the agency's fiscal agent, are available to train providers on correct billing methods."

Feds must be reimbursed

Steve Bellomy, head of Idaho's Health and Welfare's Bureau of Audits and Investigations, says that the state's $1.5 billion Medicaid program is facing new challenges with its utilization management approaches. This is mainly due to increasing enrollment and shrinking revenues.

"Our top challenges include the troubled economy, finding and defining our mission, and improving our efficiency and effectiveness," says Mr. Bellomy. "But for a small state on a tight budget, Idaho has a great deal happening to improve program integrity in Medicaid."

Last year, Idaho Medicaid identified $3.2 million in overpayments and $2.5 million in cost savings. One new challenge going forward, however, is the rule under the American Recovery and Reinvestment Act (ARRA) requiring states to reimburse the full federal share within 60 days of identifying an overpayment. In Idaho's case, this is nearly 80%. "This poses a threat to the budget and places the integrity activity at odds with state funding," says Mr. Bellomy. "Pursuing repayment more vigorously jeopardizes the financial viability of many providers and could further dissuade some providers from participating in Medicaid at all. So, this has changed the way we do business. We must now analyze each case to determine how best to resolve issues, so we don't harm the state."

As Idaho is a rural state, ranking 13th in size and 40th in population, the cooperation of the medical community is necessary for these efforts to succeed. Previously, techniques such as statistical sampling were used to maximize the overpayments that were identified.

"Now, we must focus on ways to maximize the recoupment of overpayments and still remain a deterrent," says Mr. Bellomy. "This is not an easy task. Many providers are perched on the edge of solvency, and some may be wary to accept Medicaid patients. However, since our only means to obtain relief from uncollectable overpayment is bankruptcy through aggressive civil action, it is a deterrent."

Currently, Idaho Medicaid is making its utilization review efforts more effective with the help of new

technology. "All of the Medicaid integrity partners are learning to do a better job of coordinating efforts so that we are sharing the road with one another, since we each focus on a necessary mission," says Mr. Bellomy. "Providers don't know the difference between the MFCU, MPIU, the state Medicaid credentialing unit, or the MIG and MIC. So, it's our job to make the partnership transparent to the providers."

The Medicaid Program Integrity Unit always has had a good relationship with other Medicaid program units, such as credentialing, but it is learning to better coordinate efforts when it comes to dealing with providers.

"It is common for the credentialing unit to be working with a provider at the same time that the program integrity unit is conducting its own investigation," Mr. Bellomy explains. "Even though we understand the difference between credentialing and retrospective claims reviews, the provider sees us as one agency and can easily become confused [as to] why they are being visited by two separate groups. Coordination is important among *all* integrity activity."

Here are some of the ways Idaho Medicaid will use technology to improve its utilization review:

—Idaho Medicaid's new Medicaid Management Information System (MMIS) will be implemented next summer, with federal funds paying for 90% of the $50 million cost.

"The new MMIS will greatly improve Idaho's ability to manage Medicaid," says Mr. Bellomy. "The first line of defense against waste, fraud, and abuse is a strong Medicaid program. The new system should help manage and reduce risks better. It will also provide a massive amount of data from which to identify abuses."

—Idaho implemented a new statewide eligibility system in late 2009, replacing one that had been in use for 22 years.

The system was partially funded by Medicaid and other Federal Public Assistance Programs. "It, too, should help improve the timeliness, accuracy, and quality of applications for Medicaid benefits," says Mr. Bellomy.

—Idaho is now participating in the Public Assistance Reporting Information System.

"Though Idaho was an early member state, two misstarts and the implementation of the new eligibility system delayed actual participation," says Mr. Bellomy. "Idaho fully expects to take advantage of the potential cost savings in Medicaid and identify citizens who are eligible under other veterans' benefits and services."

—Case tracking software is being used to better automate processes and reduce paperwork.

"The case data is available in a data warehouse that makes it easy to create reports and share them with our partners, such as the collections unit, attorneys, and other Medicaid quality control units," says Mr. Bellomy.

—Idaho began working with the Federal Medicaid Integrity Group in September 2009.

"Idaho views this as an opportunity that we might otherwise miss," says Mr. Bellomy. The state underwent a Medicaid program integrity review that was finalized in July 2009. The State's Bureau of Audits and Investigations is reallocating staff resources to reduce administrative support and increase analytical support, through data analysis.

Even though the Medicaid program is receiving a greater federal match rate through ARRA, and enrollment is increasing, Idaho has little flexibility to shift the budget to Medicaid Integrity. This is because every program in the state is coping with budget holdbacks.

"In fact, we count ourselves lucky to have avoided layoffs to this point," says Mr. Bellomy. "Most programs in Idaho are digging deep, including a reduction in staff, to meet the budget shortfalls. The Medicaid Integrity program has to balance our actions against the interests of the state and the federal program."

Mr. Bellomy says for Idaho, "this means that we have to look beyond the simple mission of identifying overpayments. We need to make sure that every action will stop abusive practices, but not harm the state's financial position or harm the Medicaid program."

To handle the increasing caseload, Idaho will utilize technology and better coordination with its key partners. "When resources become scarce, there is only one course of action. Do things better, faster, and cheaper. Doing less is not an option," says Mr. Bellomy. "Idaho is shifting gears and changing strategy to maximize the return on program integrity efforts."

Contact Mr. Bellomy at BellomyS@dhw.idaho.gov, and Ms. Steckel at (334) 242-5600 or Carol.Steckel@medicaid.alabama.gov. ■

Chronic care project targets most expensive LTC clients

Washington's Chronic Care Management Project targets the most medically expensive, high-risk Medicaid clients in its long-term care system. It has lowered mortality and improved the health of clients with chronic conditions such as diabetes, heart disease, and musculoskeletal diseases.

"We had been designing our program to improve health outcomes, reduce medical costs, and improve

self-management skills. So, we were very pleased that it worked," says **Candace Goehring**, MN, RN, unit manager with the Aging and Disability Services Administration (ADSA)'s Home and Community Programs. "We had *not* anticipated measuring mortality rate, so that was a surprise finding."

Over a two-year period, nurses were assigned to more than 400 adults. During face-to-face interactions, clients were encouraged to take charge of their own health issues and reduce the need for health care services. Clients were connected to community-based experts and participated in dietary, pain management, and physical activity programs in addition to care management interventions.

Here are some of the approaches that make the program unique:

• Predictive modeling data is used to select potential enrollees at highest risk for future health care utilization, based on analysis of demographics, health care claims, and utilization.

"Predictive modeling data was also used to identify care opportunities for client goal setting," says Ms. Goehring. For instance, clients with diabetes who have not had podiatry care, retinal eye exams, or A1C testing, might set a goal to obtain those routine exams to improve their diabetes management.

Likewise, individuals with ED visits related to falls identify approaches to reduce their risk of future injuries. "Clients with treatments for infections, such as urinary tract or respiratory infections, identify strategies to better understand their symptoms, when to call their primary care physician, and prophylactic care," says Ms. Goehring.

• Care management with individualized assessment and intervention is provided to high-risk clients by a nurse care manager.

"This results in a plan of care jointly developed by client and care manager," says Ms. Goehring.

• Client activation levels are determined using the Insignia Health Patient Activation measure and a "coaching" approach.

Over the course of working with the nurse in a coaching relationship, clients increased their levels of activation, with more confidence in managing their own health conditions.

• Intensive care management services are provided through the state.

"These integrate acute and long-term care services, using face-to-face care management focused on supporting existing ADSA clients living in their home," says Ms. Goehring.

• The program builds on long-term care casework and in-home service delivery infrastructure through Area Agencies on Aging.

The nurse care managers work for the same organizations that provide the case management for this group of long-term care clients. "In some cases, they had previously worked with these clients to support their long-term care plan," says Ms. Goehring. "This existing relationship aided in engaging clients and bridging the network of long-term care services with the medical care the client was receiving."

• Clients remain in the project for the period of time that they are eligible for chronic care management services.

"We were able to allow the client and their caregivers to engage in the health action planning process and work towards lifestyle and behavior changes that require time and effort to accomplish and sustain," says Ms. Goehring. "A client's perception of need and readiness for change will determine the speed of the change."

The engagement rate was 43% of those targeted for the program, similar to other projects nationally. A client survey measured Overall Health Rating, Patient Activation Measure, Overall Self-Sufficiency, Pain Impact, and Quality of Life Scale. For all five areas, the results consistently pointed to better self-reported health outcomes in the treatment group than the comparison group.

"There was a statistically significant lower risk of death among the clients randomly assigned to being offered chronic care management in the 10-month study period," says Ms. Goehring. "Those in the treatment group had lower average medical costs in the first 10 months of the project than those not offered treatment, though this was partially offset by increased in-home long-term care services."

Findings from the client record review showed that nearly half of the clients in the sample achieved improvements in health condition, living environment, or access to treatment. "The greatest challenges appeared to be resource limitations, particularly in rural areas of Washington state," says Ms. Goehring.

More clients in the treatment group reported usually getting an appointment at a doctor's office or clinic as soon as they thought they needed it. Another finding was a high prevalence of mental illness in individuals with high-risk chronic conditions. "Improving health and reducing health-related costs requires intentional and individualized care planning with client-centered goal setting," says Ms. Goehring.

Second evaluation

A 22-month cost-and-outcomes evaluation found similar trends as a previous evaluation done at the 10-month mark. "We are looking towards expansion of chronic care management to more eligible clients receiving long-term care services,"

says Ms. Goehring. In the program's first round of expansion, the number of clients will increase to 1,000. Ultimately, the program could enroll as many as 12,000 people.

Although enrollees in the program were less likely to die in the 22-month follow-up period, the decreased mortality rates that were statistically significant at the 10-month follow-up have moderated over time.

The second evaluation found that enrollees were less likely to have inpatient hospital stays involving ED visits. This resulted in an estimated medical cost savings of $253 per person, per month. Overall, including the $180 per month cost of enrollment in the program, a small net savings of $27 per month was seen.

Despite these encouraging results, client engagement is and will remain a challenge for any program targeting high-need, high-cost Medicaid clients. "Offering services does not guarantee client engagement," says Ms. Goehring. "Ultimately, clients can decide whether their preference is to participate, but many of them at the point of introduction do not understand what they are declining or accepting. Over time, we are learning about approaching clients with an opt-out option, rather than an opt-in approach."

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Surprising findings on expenditures for Medicaid 'Buy-In' participants

On the one hand, expenditures for Medicaid Buy-In participants, who pay monthly premiums, more than doubled from $887 million to $1.9 billion between 2002 and 2005, as did program enrollment. On the other hand, this group was found to be less expensive than other adult disabled Medicaid enrollees, with lower average Medicaid expenditures.

This could mean that Buy-In participants who are working require fewer services, or a less expensive mix of services, than other disabled Medicaid enrollees, according to an October 2009 report from Washington, DC-based Mathematica, *Analysis of Medical Expenditures and Service Use of Medicaid Buy-In Participants, 2002-2005.*

When workers with disabilities "buy into" Medicaid by paying monthly premiums or copayments, states can offer them Medicaid coverage when their income and assets would otherwise make them ineligible. Most Buy-In participants also receive Medicare coverage if they are eligible for Social Security Disability Insurance payments. While the average monthly Medicaid cost remained fairly stable between 2002 and 2005, with a slight decrease from $1,287 to $1,224 after adjusting for inflation, the average monthly Medicare cost for buy-in enrollees with dual coverage rose from $493 to $597 over this period.

"The overall finding that total medical expenditures grew was not surprising, because enrollment was rising," says **Gilbert Gimm**, PhD, a health researcher with Mathematica.

"However, it was interesting that *average* monthly expenditures for Medicaid were stable, even though enrollment and average Medicare expenditures were rising."

This finding was important because 75% of Buy-In participants are dual-eligibles, having both Medicaid and Medicare coverage. "Thus, the analysis of Medicaid costs should also take into account what is happening with Medicare costs, because some payments may be shifting from states to the federal government," says Dr. Gimm. "It will be interesting to see the extent to which Buy-In states have shifted their financing of prescription drugs to Medicare Part D after 2006."

Most Buy-In participants are not new to Medicaid but are transferring from another eligibility category and, therefore, do not require additional state funding.

The design of a new Buy-In program includes defining the target population and health care needs, thinking about program eligibility criteria, and planning strategies for effective outreach. "For example, the training of eligibility workers to identify potential candidates is a key step," says Dr. Gimm.

Focus on younger workers

States with Buy-In programs may wish to consider focusing their outreach toward younger workers with disabilities, because they have considerable potential to improve earnings and become self-sufficient. One way of doing this is to target individuals who are attending universities or are relatively new members of the work force.

"The use of Internet web sites and social networking sites can provide a direct way to connect with younger individuals with disabilities. These channels may be underutilized by some state agencies," says Dr. Gimm. "Youth transition programs could represent a potential group of future candidates for the Buy-In program, but effective outreach would require the coordination and sharing of information across agency silos to reach these individuals."

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Changing client behavior is top challenge for decreasing ED use

There is no question that decreasing inappropriate use of the emergency department for Medicaid patients can save significant costs, but getting results is a daunting challenge.

Currently, 20 state Medicaid programs are utilizing grants from the Centers for Medicare & Medicaid Services (CMS) to provide alternative health care settings for nonemergent needs, with the goal of decreasing ED use. The funding comes from the Deficit Reduction Act of 2005, which provided $50 million to be distributed over four years (2006-2009) for primary health care programs. For the most part, the programs are located in rural and other underserved areas.

In Georgia, four grants were made to partnerships of primary care providers and hospitals to develop a primary care access point for nonemergent ED patients. Each developed its own nonemergency protocols. The grantees are in the early stages of implementation, but to date, 4,929 patients have been treated in the new primary care nonemergent centers.

"All patients receive the same screenings regardless of medical coverage," says **Jerry Dubberly**, chief of Medical Assistance Plans and director of Medicaid for the Georgia Department of Community Health. "In general, a patient seeking treatment from a hospital ED for a nonemergent condition is encouraged to seek care from a primary care provider, which may be the primary care center funded under the grant."

Education is key

Washington Medicaid hasn't yet formally evaluated its program to decrease ED use, but changing client behavior is proving to be a significant challenge. "The strategies make sense in terms of after-hours care and providing alternatives for individuals. But there is a huge client education component to this. We need to help people to think of alternative ways to seek care," says **MaryAnne Lindeblad**, Medicaid division director.

Ms. Lindeblad says in the long term, she expects to see more tangible results from the state's new focus on person-centered medical homes. "That will provide a better delivery system and will give folks 24/7 access to someone or something. I think that will probably be more successful in the long run than some of these more narrowly targeted interventions that we have been able to make so far through the grant."

Most of the communities with initiatives in place are looking for ways to manage what is often referred to as the "frequent-flier" population. These individuals often need additional care management, and they need to be linked to providers and community resources for after-hours care. "I think there will be some good things coming out of the grant," says Ms. Lindeblad. "But in the end, we need to give them self-management strategies, too."

The first step is to provide some education to Medicaid clients, who don't always understand when it is appropriate to use an ED. "We were able to get a fast-food restaurant to put information about ED use on the paper placed on their trays. And we are looking at doing this at other places where low-income families might go," says Ms. Lindeblad.

Appropriate alternatives needed

The Georgia Department of Health encourages Medicaid members to establish a medical home by choosing a primary care physician as soon as possible. According to Mr. Dubberly, "the biggest challenge is changing member behavior to seek care in the most appropriate setting. Over the long term, we hope to see healthier Medicaid members who establish a medical home and fully utilize their benefits for preventive care rather than urgent care."

Utah's Emergency Room Diversion Grant of $503,000 was used to provide an intervention to identified clients who used the hospital ED for nonemergent care. The population was initially limited to people in the Wasatch Front, an urban area, but has since been expanded statewide.

Patients are encouraged to seek

care from a family practitioner or physician at community health centers and are informed of instances when it is appropriate to visit an ED. One of the goals was to attempt to determine *why* patients decided to visit the ED for nonemergency care instead of their physician or community health center.

"The intervention is geared toward changing a client's behavior," says **Gail Rapp**, director of the managed health care bureau. "There are three levels of intervention." These are as follows:

1) When clients have a first nonemergent use of the ED, a friendly letter is sent that educates them about the provider choices available of a primary care physician, an urgent care center, and a hospital ED. They are instructed to choose the most appropriate facility for their care. "A list of urgent care facilities in Utah is included," says Ms. Rapp. "Also, staff offer clients help in finding a primary care provider."

2) Clients are sent a second letter when there is a second nonemergent use of the ED. "The second letter is more direct, and warns the client that continued use of the ED for nonemergent care may warrant enrollment in the Medicaid Restriction Program," says Ms. Rapp. A list of urgent care facilities in Utah is again included with the letter.

3) A third nonemergent visit to the ED moves a client into review status in the Restriction Program. "A standard Restriction Program letter about misuse of the ED is sent to these clients," says Ms. Rapp. "Once enrolled in the Restriction Program, the client is assigned a single primary care provider and pharmacy."

Full evaluation of the program's effectiveness will be completed during the second quarter of 2010. "It is our goal to show a reduction in nonemergent use of the ED in the group that received the intervention," says Ms. Rapp. "The biggest challenge is locating appropriate alternatives where people can go for urgent care rather than rely on the ER."

"The department's focus is on maximizing the health of our clients, ensuring timely access to needed services and maintaining the affordability of care. Implementing efforts to decrease nonemergent, emergency room visits is one of the ways we are supporting the value of having a medical home and receiving preventive care."

— Sandeep Wadhwa
Colorado State Medicaid Director

A questionnaire sent to clients revealed that a large number of respondents were not aware of an urgent care provider in their area. To address this, a questionnaire was sent to all Medicaid contracted group providers statewide asking them if they offer urgent care, extended hours beyond Monday through Friday from 8 to 5, and if they see patients without an appointment.

"We've received a good response from the providers, and we are building a database of urgent care providers," says Ms. Rapp. "Over the long term, we hope to see increased awareness by both patients and doctors of the urgent care providers in the community."

Another problem revealed by the client questionnaire was that a significant number of clients were told to go to the ED by their primary care doctor. "We would like to see doctors suggest using an urgent care [center] when they feel their patients should not wait for a regularly scheduled appointment in their offices," says Ms. Rapp. "We believe providing information about alternatives to using the ED to the decision maker—the patient—will result in a reduction in using the ED replaced by a rise in using urgent care."

Innovative communication

"Decreasing nonemergent emergency room visits is a key component in improving health outcomes and decreasing Colorado Medicaid costs," according to **Sandeep Wadhwa**, MD, state Medicaid director. The Department of Health Care Policy and Financing began efforts to decrease the improper use of emergency departments (EDs) in 2008.

In 2008, the department was awarded a grant from CMS of $1.8 million over a two-year period. The goal of the funding was to explore ways to improve access to primary medical care, so that Medicaid clients could avoid improper use of EDs and receive proactive, preventive care rather than waiting until conditions become exacerbated. The department granted these funds to two community health centers, Valley-Wide Health Systems and Peak Vista Community Health Centers.

The Convenient Care Community Clinic opened by Valley-Wide Health Systems in November 2008 has averaged more than 1,000 visits per month, with Medicaid clients comprising one-third of these visits. In one year, more than 300 people with nonemergent conditions were deferred from the ED to the clinic. About 12,000 additional people chose to make appointments at the clinic without going to the ED.

Peak Vista Community Health Centers collaborated with a local

hospital, Memorial Health Systems, to station staff in the hospital's ED during the busiest hours of the week. After a client has been seen in the ED, staff explain the availability of primary care and how this improves overall health and reduces the need for emergent care.

In one year alone, Peak Vista has connected with more than 7,000 people visiting the ED at Memorial Health Systems, with follow-up appointments offered at the clinics. "Of the people contacted, 2,000 made *and kept* clinic appointments," says Dr. Wadhwa.

Peak Vista has provided immunizations to more than 300 children who were referred from the emergency room, and provided routine primary care tests to 130 clients with diabetes, who were referred from the ED. "These clients now have a medical home and will receive primary, preventive care," says Dr. Wadhwa. "The department's focus is on maximizing the health of our clients, ensuring timely access to needed services and maintaining the affordability of care. Implementing efforts to decrease nonemergent, emergency room visits is one of the ways we are supporting the value of having a medical home and receiving preventive care."

Direct communication with clients is accomplished through a variety of innovative methods. A survey was conducted at nine hospitals to determine what prompted the client to visit the ED. The most common response was that clients thought their condition was serious. About 80% of respondents said they would talk to a nurse over the telephone about their condition before going to the hospital.

"The results from the survey provided key information for the development of a plan to decrease nonemergent emergency room visits, and they serve as a baseline for future evaluation," says Dr. Wadhwa. The 24-hour Nurse Line is being broadcast on the department web site, included in all eligibility correspondence to Medicaid clients, and will be on all Medicaid benefit cards beginning January 2010.

After identifying high emergency room utilizers, letters have been sent to clients who have visited an emergency room at least six times in nine months. The letters informed clients of the availability of the Nurse Line and its value to them personally, such as no waiting time, no need for baby-sitters, and less cost. It provides a telephone number to help them find a primary care doctor.

There is a long-term plan to give hospital incentives using ED visits as an indicator, which would be made possible through the Colorado Health Care Affordability Act. "Budget cuts have not, and will not, affect the innovations for decreasing emergency room visits for nonemergent care," says Dr. Wadhwa.

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