State Health Watch
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No "wait and see" approach for Medicaid expansion

Will the Patient Protection and Affordable Care Act (PPACA) survive in its current state, be significantly altered, or even be repealed altogether? More than two dozen cases in federal courts across the country are currently challenging various aspects of the law, notes **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC.

In December 2010, a Virginia federal judge ruled that it is unconstitutional for the government to compel Americans to buy health insurance. However, the ruling did not force federal and state officials to stop the work of putting PPACA into effect, says Mr. Dorn.

"The Attorney General brought suit and got a favorable decision in the district court; but despite that action taken at the executive level of Virginia state government, there is still a lot of planning process at the agency level," says Mr. Dorn.

Mr. Dorn says that there is "an interesting dichotomy between the top-level political leadership, which in some cases has been very hostile to the federal legislation, and agency staff, which is moving ahead in a very practical way and trying to make sure that residents benefit from the federal law."

*See **Cover story** on page 2*

Arizona Medicaid needs $1 billion to fund current program for FY2012

Arizona will have to spend $11.6 billion in general fund monies from fiscal years 2011 through 2020 to serve expansion and "woodwork" populations, as well as maintain previously optional groups that are now mandated by the federal government, according to an analysis of the impact of the Patient Protection and Affordable Care Act (PPACA) that was completed by Arizona's Medicaid program.

"The biggest issue for Arizona is that we cannot afford the program we have, once the federal stimulus funds expire on July 1, 2011," says **Thomas J. Betlach**, director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program.

"Significant" intangible costs

Currently, Mr. Betlach says, "We need $1 billion in fiscal year 2012, just to fund the current program. That is in a state where we have cut state government spending by over $2.2 billion since the start of the recession, and have had to raise

Fiscal Fitness: How States Cope

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State Health Watch
The Newsletter on State Health Care Reform

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Cover story

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Still, Mr. Dorn acknowledges there is some uncertainty, "and that has to affect people's attitudes in moving forward."

Behind-the-scenes work

Mr. Dorn says that despite the turmoil in the headlines, a lot of work is taking place "behind the scenes," as states move forward with implementing the federal law.

"State officials understand that it will take everything they have to implement this law," says Mr. Dorn. "They can't sit around and wait, based on the possibility that it could be repealed or greatly changed."

Mr. Dorn says that "if officials do sit and wait, and the law remains in place, they will be lost. State agencies are moving ahead full speed. At the same time, they are keeping one eye over their shoulder, understanding that things could change dramatically between now and 2014."

This is a definite challenge, he says, "but state health officials are used to very challenging situations. The budget situation in most states is horrendous right now. That is a huge challenge."

Mr. Dorn notes that states moved forward with the Children's Health Insurance Program (CHIP), regardless of the fact that it had a finite life. "It was subject to tremendous federal wrangling between Congress and the Bush administration before it finally got extended in 2009," he says, yet state officials continued implementing innovative strategies to cover otherwise uninsured children. "So, we're dealing with a hardy bunch."

If states don't move ahead with vigor, adds Mr. Dorn, they will lose out to other states. "In many cases, there are only so many federal grants available, and only so many federal demonstration projects that will take place," he says. If one state doesn't move forward, another will be glad to take that available federal dollar or that available federal option, Mr. Dorn says.

Planning work continues

Toby Douglas, chief deputy director of the California Department of Health Care Services and the state's Medi-Cal director, says that the planning process is not being affected in any way due to uncertainty over health care reform's future.

The most important unanswered questions for Mr. Douglas right now, he says, are "the state budget deficit, the state's approach to eligibility systems development, and the need for federal guidance on modified adjusted gross income rules."

Charles Duarte, administrator for Nevada's Division of Health Care Financing and Policy, says, "We are working under the philosophy that the ACA is the law until it is not the law. Therefore, planning and implementation work is continuing."

Mr. Duarte says that first and foremost, he is waiting to see whether the federal government will fully fund the development of the health insurance exchange that will serve as an insurance marketplace in 2014. "There are many, many other questions, but that one is key," says Mr. Duarte. "There also remain numerous policy decisions to be made at the state level, which will require the involvement of the governor-elect and the legislature."

Donna Friedsam, health policy programs director at the University of Wisconsin Population Health Institute in Madison, notes that Wisconsin elected a Republican governor and Republican-controlled legislature, a change-over from a Democratic governor and legislature.

Gov.-elect Scott Walker plans to authorize Wisconsin to join the state

lawsuit against the PPACA, and he opposes the individual mandate, adds Ms. Friedsam. "He is not favorable to most of the provisions, although he has signaled interest in building a free-market-oriented insurance purchasing exchange," she says.

Ms. Friedsam says regarding Medicaid, the Governor-elect and new legislature are going to look for ways to roll back Wisconsin's "currently very generous" eligibility rules that cover children up to 300% of Federal Poverty Level (FPL), and parents/caretakers and childless adults up to 200% FPL.

"The ACA, of course, contains maintenance of effort provisions for children's coverage through 2019," says Ms. Friedsam, noting that states with deficits do not have to meet maintenance of effort provisions for adults.

"In terms of the uncertainty in Washington, our state's new governor is counting on the roll-backs at the federal level to enable him to pursue his agenda," says Ms. Friedsam. "He does not want to be bound by federal requirements for operating exchanges or regulating insurance."

Ms. Friedsam reports that Wisconsin's advanced eligibility and enrollment system, ACCESS, utilized for its Medicaid/CHIP programs, is currently being engineered to operate for use by a potential exchange. "This work continues. The ACA is still the law, and the funding continues to flow to states to put these systems in place," says Ms. Friedsam. "This is occurring at a staff level. I believe other states are still proceeding in this manner as well."

Ms. Friedsam says that she wouldn't characterize the approach as "wait and see" but rather, "proceeding cautiously." However, she acknowledges that uncertainty is difficult in any business environment.

"Soon enough, policy decisions that occur at the federal and state levels will affect the on-the-ground planning and contracting decisions being made in agencies," says Ms. Friedsam.

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Fiscal Fitness

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taxes by over $1 billion."

This means more than $1 billion a year in new unfunded federal mandates, says Mr. Betlach, adding that there are significant intangible costs to health care reform. "Just about every component of health care reform will require added complexity," he says.

For example, Arizona has 18 different health plans, and the law requires that Medicaid reimburse certain professional fees at 100% of Medicare, says Mr. Betlach.

"We currently reimburse at 95%, on average, on our fee scales. Plans may literally have hundreds of different negotiated rates with providers," says Mr. Betlach. "Do we need to somehow track all of that to ensure that they each all get up to 100%, and then account for it financially so that we can get some additional federal match?"

Mr. Betlach questions how the state will be able to get this done, especially since over 30% of staff has been lost since the start of the recession due to budget cuts. "In addition, 35% of the remaining staff are eligible for retirement over the next five years," he adds. "That is a lot of institutional knowledge and expertise being lost at a critical time."

Mr. Betlach says that there were "no significant surprises" in the analysis provided to the governor. "The analysis largely mirrored the evaluation that had been completed throughout the legislative process, which served as one of the main reasons Gov. [Janice] Brewer strongly opposed the legislation," he adds.

The biggest challenges for AHCCCS currently, says Mr. Betlach, involve both short-term and long-term finances.

"The biggest challenge is, what do we do when the stimulus funds expire?" he asks. When that happens, the state match requirement for the Arizona General Fund will go from $2 billion to $3 billion, he says.

"This is in a state that has already had to enact budget reductions throughout state government in excess of $2.2 billion and had the voters pass a tax increase that approaches $1 billion," says Mr. Betlach.

Some difficult decisions

Since the start of the recession, says Mr. Betlach, the state has made budget policy decisions that have reduced spending by $875 million from a Medicaid program that is regularly ranked as having one of the lowest per member/per year costs in the country.

These reductions have come from provider rate reductions, benefit changes, reductions in eligibility in the Children's Health Insurance Program (CHIP), and increased cost sharing.

"States have limited options, given the maintenance of eligibility [MOE] requirements imposed by ARRA [the American Recovery and Reinvestment Act of 2009] and the Affordable Care Act," adds Mr. Betlach.

To date, says Mr. Betlach, Arizona has imposed provider rate reductions ranging from 5% to 10% and has frozen payments to hospitals and nursing homes for two years. On April 1, 2011, payment

to Arizona Medicaid providers will be reduced by an additional 5%, he adds, including hospital payments.

Coverage was eliminated for many optional benefits, including emergency dental procedures, insulin pumps, and orthotics, says Mr. Betlach, and mandatory copays were imposed on roughly 225,000 adults.

"These are difficult decisions that are being made," says Mr. Betlach. "One that has grabbed attention is the decision to eliminate certain transplants."

Currently, about 100 transplants are covered each year, Mr. Betlach says, and after benefit changes were made, this will be reduced to roughly 85 transplants, saving $800,000 in the current fiscal year. In 2009, AHCCCS had both internal and external clinicians review medical research and outcome results for the program, he reports.

"Ultimately, policy-makers approved the proposed changes," says Mr. Betlach. "Of course, the decisions made at the state level are largely shaped by federal policy. Congress has clearly established transplants as an optional service."

Mr. Betlach says that "ultimately, this is a decision made by voters about what level of services they are willing to support with their tax dollars. To date, we have not seen a campaign launched by the voters or provider community to address the $1 billion problem."

In light of this, Mr. Betlach says that further reductions to the AHCCCS program and other state-funded programs are inevitable. "After the benefit changes were made, Arizona has very few optional benefits remaining," he notes. "At the same time, we face incredible fiscal pressure in the upcoming year."

MOE requirements

Mr. Betlach notes that as a result of the MOE requirements in health care reform, Arizona restored its CHIP program, KidsCare, which was eliminated in the FY 2011 budget.

Prior to the passage of the PPACA, the Centers for Medicare & Medicaid Services (CMS) approved a freeze on new enrollment for KidsCare as of Jan. 1, 2010, explains Mr. Betlach.

"The legislature took action and restored the CHIP program, when it was apparent the state would lose $7 billion in federal participation if the program was eliminated," says Mr. Betlach.

The biggest challenge of health care reform, according to Mr. Betlach, will be meeting the MOE and financial match requirements. "Arizona is one of just a handful of states that provides coverage to childless adults up to 100% of the federal poverty limit," he notes.

One week before the passage of health care reform, the Arizona legislature enacted a budget that would have eliminated coverage for 300,000 adults, reports Mr. Betlach, which would have resulted in annual savings to the state of roughly $1 billion.

"Once health care reform was enacted, this option was eliminated," he says. "Given that Arizona is trying to manage a program it cannot afford, meeting the MOE requirements are a massive challenge."

Growth is continuing

Mr. Betlach says that once health care reform is initiated, meeting the continued fiscal pressures will continue to place a strain on the state.

"Our estimates show the projected state match that will be required between now and fiscal year 2015 will only grow," says Mr. Betlach. "The state continues to face significant growth associated with the Medicaid program."

The additional resources required to support Medicaid means more reductions in K-12 and university funding, says Mr. Betlach, as the Medicaid program continues to take up a bigger percentage of state government spending. This percentage has increased from 18% in fiscal year 2007 to 30% in fiscal year 2011, he reports.

While it won't result in immediate fiscal gains, Mr. Betlach says that one of the best long-term opportunities he sees under health care reform is the new authority provided to states to address coordination issues for dually eligible members.

"Arizona is interested in leveraging our mature managed care model, and applying for assistance being offered by the new Center for Medicare and Medicaid Innovation and the Coordinated Health Care Office," says Mr. Betlach. "The Affordable Care Act provides new flexibility for states to develop new demonstration proposals."

Arizona has about one-third of the 100,000 dual eligible members enrolled in the same plan for both Medicare and Medicaid, notes Mr. Betlach. "Arizona is looking to eliminate regulatory confusion and improve the experience for this frail population," he says.

Arizona is exploring other areas for potential improvements in the delivery of care and cost containment relating to patient-centered medical homes, adds Mr. Betlach.

"We look forward to working with CMS to see what opportunities states may have to improve outcomes for dual-eligibles and to better manage the health of the broader Medicaid population," he says.

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What is most likely outcome for Medicaid expansion and health reform?

As speculation continues regarding the future of the Patient Protection and Affordable Care Act (PPACA), state Medicaid directors are continuing with their planning process, says **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC. "There is always a lot of posturing. After Medicare Part D passed, there was posturing," says Mr. Dorn. "But it's much harder to repeal a law than to create a law. I think it is realistic to assume it is going to go forward."

However, **Thomas Miller**, JD, a resident fellow at the American Enterprise Institute for Public Policy Research in Alexandria, VA, says that over the next two years, "early measurable effects of PPACA-style health reform will remain disappointing."

Mr. Miller adds that he expects that Capitol Hill hearings "will begin to dent it further. A few shots at funding some narrower aspects of early implementation may succeed, and state resistance, both in the courts, [legislatures], and among many Republican governors, will grow."

Mr. Miller anticipates that the longer-term future of this health care reform approach will be largely determined in the 2012 presidential election. "No big dollars start to flow until 2014. The essential PPACA coverage infrastructure, including the intersection of big Medicaid expansion and subsidized exchange coverage, doesn't get cemented into place until 2013," he says.

The implications for state Medicaid directors depend on their state's political climate, says Mr. Miller. "The competing tendencies are to just hunker down and ask, 'Just tell us what you want us to do,' and 'We will continue to pretend to do the impossible,' versus 'Hold your fire and do the minimum necessary while continuing to ask for more guidance that is slow to arrive, and then complain about it once it does,'" says Mr. Miller.

The biggest issues, says Mr. Miller, are whether state budgets can withstand the Maintenance of Effort requirements until 2014, and whether the proposed health insurance exchanges will actually turn out to be "real" and capable of administration. "There are lots of moving parts in theory that have never been assembled in such complexity before," he says.

As for states that have sued to overturn the legislation, Mr. Miller says that those states "can operate on parallel tracks to some degree, but with less enthusiasm and fill-in-every-detail exactitude in planning and preparation, for what they hope does not fall into place as originally designed."

Mandate is the focus

Austin Frakt, PhD, a research assistant professor of health policy and management at Boston University School of Public Health, notes that Virginia's recent court decision "doesn't invalidate the law. It just takes out the mandate. So, the Medicaid aspects of the law wouldn't be affected by that."

As for Washington politics, Dr. Frakt says that most of the talk is about the mandate, not the Medicaid expansion. "I haven't heard anyone target the Medicaid aspect, but in the general climate of belt tightening, maybe they will. There is a lot of money there."

Dr. Frakt says that although there are states that want to make major changes, such as pulling out of Medicaid altogether, "as far as I can tell, those don't seem to make a lot of sense. Pulling out of Medicaid and giving up federal dollars is a big loss."

Dr. Frakt adds that "even if states are right that they could do something more efficient, it's hard to make up for 50, 60, or 70% federal Medicaid matching funds. That level of inefficiency does not exist in Medicaid."

Many desperate for care

While Dr. Frakt concedes that "we have a pretty difficult deficit situation, and a political climate that's not really conducive to spending more," he remains hopeful that no changes will occur that result in fewer people being insured than is currently predicted.

This is particularly important for low-income individuals, he says, because "they can't go anywhere else. There aren't affordable private insurance options for them. Many of these people are very sick and in desperate need of help. Many have just missed the Medicaid cutoff for some time and are waiting for some relief."

Dr. Frakt adds that he is a "little bit disappointed that there isn't more of an outcry" over the decision for Arizona Medicaid to stop paying for certain transplants of the heart, lung, pancreas, and bone marrow, which took effect October 2010. "We should really be concerned about that, and frankly, ashamed that we are not doing better in this country," he says.

Looking forward, Dr. Frakt says that there is no question that the phase-out of additional fed-

eral money for state Medicaid programs "is going to be painful. Health care is expensive, and this is a population that doesn't vote much. They are not making political contributions, that is for sure," he says. "I can see the temptation to make cuts there, but it's not the right thing to do."

Dr. Frakt says that Medicaid is structured in a way "that invites these kind of challenges," being a joint state-federal program.

"It isn't as though there isn't money, broadly speaking, in the system, that can be directed to Medicaid programs as opposed to elsewhere," says Dr. Frakt. "The dollars that might be spent on Medicare could be better utilized on Medicaid, but it just doesn't work out that way. Politically, that is not the squeaky wheel."

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Savings differ not only by state, but also by area of government

States have the potential to save significantly under the Patient Protection and Affordable Care Act (PPACA), according to a new analysis of its fiscal impact. Although the federal legislation will require states to increase their spending on Medicaid coverage for low-income adults, those costs will be greatly outweighed by potential state savings in several areas, according to researchers at the Urban Institute in Washington, DC in their December 2010 study, *Net Effects of the Affordable Care Act on State Budgets*.

The researchers considered savings that will come from shifting some of today's higher-income Medicaid adults into the health insurance exchange, where the federal government will pay for all of their subsidies. They also looked at the savings from substituting newly available federal Medicaid dollars for current state and local spending on uncompensated care, as well as mental health services provided to low-income residents.

According to the analysis of these three areas, state savings during 2014 to 2019 will exceed state costs by $40.6 billion under a worst-case scenario, and $131.9 billion under a best-case scenario.

States can come out ahead

"There are a lot of reports that states have done that look only at the cost of health care reform," says **Stan Dorn**, the study's lead author and a senior fellow at the Urban Institute in Washington, DC. "And there is no question, health care reform will impose a lot of costs on states."

Some additional people who are currently eligible will enroll, and states will have to pay their normal share, notes Mr. Dorn. After 2016, the federal government will stop paying for all the costs of newly eligible adults.

"But on the other hand, states have opportunities to achieve fiscal gains," says Mr. Dorn. "The reports that look at both sides of the ledger find that on balance, states can come out ahead."

The researchers, says Mr. Dorn, "used pretty conservative assumptions, and we found that just in the three areas that we looked at, states can achieve savings that vastly outweigh costs."

However, Mr. Dorn acknowledges that this may not be the case for all states, or for Medicaid programs in particular. He says that this brings to mind the saying, "where you stand depends on where you sit."

"Sometimes the cost hits one part of state government, and the savings hit a different part," says Mr. Dorn. "The question is, who gains?"

Medicaid may face increased costs and a big increase in the number of enrollees, while a mental health program may receive significantly more federal reimbursement, says Mr. Dorn. Local programs that pay for indigent hospital care also stand to benefit disproportionately, says Mr. Dorn. "In California and Texas, for example, a lot of uncompensated care is paid for by local tax dollars," he says. "The state may be worried that it will see increased Medicaid dollars, but the localities may be thrilled because of the increased revenue that is coming their way."

Some states vigorous

If an uninsured person gets coverage through his or her state Medicaid program and avoids being hospitalized because he or she has better access to care, Medicaid is still spending more than if that person had remained uninsured, notes Mr. Dorn. On the other hand, he adds, the cost of uncompensated care is going to go down in this scenario.

"We've seen differences in states when coverage through Medicaid and CHIP [the Children's Health Insurance Program] became much more generous to kids than adults in the late 1990s," says Mr. Dorn.

Some states were "very vigorous" in maximizing their pursuit of federal Medicaid dollars to substitute for previous state and local spending on children, recalls Mr. Dorn. He

predicts we will see the same pattern occur with adults under the PPACA.

"Some states will invest time, effort, and creativity in figuring out how to get the best possible deal for their taxpayers; others will be left behind," says Mr. Dorn. "We know how this is going to play out."

Some states will come up with clever ideas and "push the envelope," says Mr. Dorn, and other states will follow suit. "People in the federal government will crack down and prevent further expansion, while 'grandfathering in' the trailblazing states," he says. "The other states left out of the party will never be able to join in and get what their colleagues received. We've seen this play out time and again."

Low- and moderate-income uninsured adults are going to have health coverage through Medicaid, in many cases with 90% to 100% federal funding, notes Mr. Dorn, or in some cases through federal subsidies in the health insurance exchange.

"States have been spending a lot of money providing health care services to adults who are now going to get coverage," he says. "There are a lot of opportunities, fiscally, for state budgets."

One possible obstacle, says Mr. Dorn, is the current scarcity of administrative resources.

"Obviously, states have experienced terrible budget cuts, layoffs, and furloughs. There is not a huge amount of staff sitting around with plenty of free time," says Mr. Dorn. "States have had difficulty just applying for federal grants, much less putting together creative strategies for maximizing their fiscal gains under the legislation."

States are struggling to answer many pressing questions, says Mr. Dorn, such as what to do with mental health services, how much more Medicaid revenue is going to come in, and whether to choose the "Basic Health" option under federal law, which might let states tailor federally funded benefits to have a bigger impact on the bottom line.

"These are not necessarily such easy questions. It takes time and effort, which ultimately means money, to figure these things out," says Mr. Dorn. "And not all states have that ability." ■

New fraud detection requirements — and opportunities — for Medicaid

Under a proposed rule from the Centers for Medicare & Medicaid Services (CMS), states would have the authority to impose a moratorium on provider types, as long as they can show this will not impact access to care.

This requirement will be very helpful to states, according to **Ann Page**, RN, MPH, director of Health Care Accountability Administration for Washington DC Medicaid.

"We and other states are sometimes inundated, because health care can sometimes be very profitable," says Ms. Page. "You may have more people trying to get into the program than you actually need."

At a time when states are struggling with budget deficits and layoffs, Ms. Page says that "it's a challenge to run an efficient program when you have more providers than you have people who can monitor them."

Under the Patient Protection and Affordable Care Act, each state Medicaid program was required to contract with one or more Recovery Audit Contractors (RACs) to identify underpayments and overpayments to providers and recoup overpayments.

As a result of these changes and other requirements in health care reform, Ms. Page says that states will have to put new operational procedures in place that weren't mandated before. "That certainly is going to challenge states in a time of pressing budgets, but maybe this will save us heartache down the road," says Ms. Page. "We can put the safeguards in up front, and hopefully avoid fraud and waste."

Up-front safeguards are key

Ms. Page notes that it's much harder to "pay and chase" than to "cost-avoid." "It's real hard to pay a provider and chase them down for money owed," she says. "We do have providers who we have sought prosecution on, and they disappear. We don't get that money back."

For this reason, says Ms. Page, the department has set out to limit opportunities for wrongdoing. "I think that's the intent of the federal legislation — to identify best practices and sound practices that all states should have in place," she says. "These will serve as safeguards to prevent fraud and abuse from happening in the first place."

Ms. Page notes that the legislation requires more disclosures of owners, managing employees, and others with financial interest in companies. This information, says Ms. Page, will allow states to check federal databases for the names of people who are not allowed to do business because of past wrongdoing.

"It will require more work on the part of states, and more work on the part of providers, because they will have to disclose more," adds Ms. Page. "The purpose is to screen for bad apples who have done wrong in the past, and to keep those parties

from abandoning business A and reconfiguring themselves as business B."

New RAC requirement

Ms. Page says that DC Medicaid's compliance with the RAC requirement "will be a supplement to the work we do in-house. There will be more resources brought to bear on this."

Providers will be facing more review than they have in the past, says Ms. Page, but they stand to benefit fiscally over the long term. "Medicaid can't always pay providers as much as it would like," she says. "To the extent that we are not making fraudulent payments, that means we have that much more in our budget to reimburse all of our providers."

Mike Blackburn, bureau chief of Florida's Agency for Health Care Administration's Medicaid Program Integrity, says, "One thing that will present a challenge is the expansion of Medicaid and the number of recipients expected to be brought in to the program."

As for the CMS proposed rule, Mr. Blackburn says "there are a few things that affected us, and some things that we were already doing that were reinforced." The Florida Medicaid Program did have to implement the national Correct Coding Initiatives, and the edits are now up and running, says Mr. Blackburn.

For the RAC requirement, Mr. Blackburn says that Florida already had some appropriation language requiring the program to do a contingency-based contract for a post-payment auditor. "So, we had that already under way. With some very small modifications, we will be able to meet that requirement without any problems," says Mr. Blackburn.

Although Florida already had the field available for the National Provider Identifier (NPI), it had not taken the steps to require that in order to pay a claim.

"We did have the capability to record the number," Mr. Blackburn explains. "We were just not denying claims if we didn't have it and were allowing Medicaid providers to submit their regular Medicaid ID." As of Jan. 1, 2011, an NPI number must be on a provider-submitted claim in Florida, or it will deny.

The agency was already required to terminate any provider who had been terminated by another state Medicaid program, and exclude providers if they were already on a federal exclusion list, says Mr. Blackburn.

Mr. Blackburn notes that payment suspensions for fraud investigations are now a federal requirement, while this was previously done at the state's discretion. "We did have some leeway," he explains. "If we thought payment should be suspended, we certainly had the authority to do that. Now, if we make a fraud referral, we have to suspend payment."

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Medicaid combats fraud with better screening and more targeted audits

Mike Blackburn, bureau chief of Florida's Medicaid Program Integrity, says that the agency has multiple fraud prevention initiatives under way, "though it may be too early to call them complete successes." He says that the post-payment auditor that will meet the RAC [Recovery Audit Contractors] requirement will be a big help in supplementing what the Medicaid Integrity Group is able to do.

"We are also enhancing our background screening and working with other parts of the agency to do that," reports Mr. Blackburn. The Medicaid Integrity Group is working with Health Quality Assurance, which licenses medical facilities; the Department of Health, which licenses Medicaid practitioners; and the Florida Department of Law Enforcement (FDLE), which does background screening.

"We are looking to enhance that process. We are even looking at retaining fingerprints for up to five years," says Mr. Blackburn. "So, even if they pass the initial screening, if they are subsequently [convicted], FDLE will alert us to that conviction."

Currently, whether it's a Medicaid fraud control unit arrest, a state attorney's arrest, or a local sheriff's arrest, alerting the Medicaid Integrity Group about a conviction is a manual process, says Mr. Blackburn, "and that doesn't always work."

Better auditing ability

"Making sure we target our audits appropriately is always a challenge," says Mr. Blackburn. "We have a Request for Information on the street right now designed to provide the state with information regarding options for prepayment use of technology to detect and deter Medicaid fraud, abuse, and overpayments. If we are able to procure some advanced detection technologies, we will be able to get more 'bang for our buck,' so to speak, for the time it takes us to do the audits."

This technology will help to identify a specific provider who is an outlier, or whole provider categories or service types that show a high risk of potential for overpayment, says Mr. Blackburn.

Mr. Blackburn notes that "there is a big provider and recipient population down in Miami, and that is where a lot of the fraud is occurring."

Two pilot projects specifically targeting fraud in Miami-Dade County were implemented on July 1, 2010. Both involve home health agencies, which were identified as a particular service type that needed more scrutiny, says Mr. Blackburn.

The "Telephony" project requires home health aides to call in to a vendor when they arrive, he says, and again when they leave. "They verify the duration of the visit, and that the individual is indeed there providing services," says Mr. Blackburn.

The project utilizes Interactive Voice Response Authentication technology to verify the presence of a direct care home health service provider in the recipient's home. The nurse or home health aide must call a designated toll-free number at the beginning and end of each home health visit and repeat a standard phrase for voice verification.

"The system will verify that the voice recorded during the check-in and check-out calls matches the voice previously recorded on their system," says Mr. Blackburn.

Face-to-face assessments

The other pilot project involves an on-site care monitoring program for home health-related services. "The purpose of the project is to identify potential overutilization and potential fraud or abuse of Medicaid services, by ensuring that the level of services provided match the needs of the recipients," says Blackburn.

Registered nurses do a minimum of 250 home visits each month to perform a face-to-face assessment of the recipient. The results of the assessment are compared against documentation provided by the home health agency and/or the prescribing physician during the prior authorization process, explains Mr. Blackburn.

Based on the outcome and findings from the home visit, the vendor may determine that a more intensified review is required, says Mr. Blackburn, which could include consultation with the physician ordering the services, review of the recipient's medical records, or an on-site visit to the home health agency performing the services.

Four percent of the face-to-face assessments done in November 2010 resulted in a recommendation to reduce or terminate services, reports Mr. Blackburn, with 21 referrals made to the Bureau of Medicaid Program Integrity.

Recoup funds owed

"Even before the recent federal interest in fraud and abuse prevention, our agency has always taken an aggressive approach to preventing fraud and abuse," says former Alabama Medicaid Commissioner **Carol Steckel**, who also serves as president of the National Association of Medicaid Directors. "Still, we always believe we can do more."

Ms. Steckel reports that the Alabama Medicaid program is taking an innovative approach, by embarking on a two-year contract with a company to identify funds that may be owed to the state by conducting a focused post-payment claims review.

"The company only receives payment when funds are recovered, so it is a win-win for the state and the company," she says. Alabama Medicaid will work with the company to review claims filed for the past two years by all provider groups in the state of Alabama, says Ms. Steckel, including hospitals, physicians, dentists, pharmacies, durable medical equipment companies, and home health care providers.

"The goal of this agency is to make sure every public dollar is properly spent to improve the health of the people of Alabama," says Ms. Steckel. "A contingency-based contract ensures that Alabama taxpayers are only paying for results."

Alabama Medicaid will be provided with a full range of fraud, waste, abuse, and overpayment identification and collection tools and services, including data mining, analytics, and detection algorithms, says Ms. Steckel.

This will bolster Alabama Medicaid's comprehensive Program Integrity initiative, says Ms. Steckel, which includes these components:

- a review of the list of sanctioned individuals, to ensure they are not working in any capacity for an entity that receives payments from Medicaid or Medicare;
- a more rigorous review of any provider enrollment application in which the applicant has previously been sanctioned or suspended;
- a requirement that any Medicaid beneficiary who has his or her eligibility reinstated after being suspended from the Medicaid program for drug-related fraud, abuse, or misuse of benefits will be placed in the restriction program and have his or her utilization of benefits monitored for one year;
- a review of new applications of durable medical equipment providers prior to enrollment, to ensure they have a legitimate office and staff;
- measurement of the accuracy of the agency's eligibility determination process. "This consistently out-performs the national average of 3%," reports Ms. Steckel. "In fact, the agency's most recent error rate was only one-half of 1% for the year." ■

Track new eligibles effectively, or lose out on higher federal match

Beginning in 2014, states will receive much higher federal reimbursement for newly eligible Medicaid beneficiaries, notes **Judith Solomon**, co-director of Health Policy at the Center on Budget and Policy Priorities in Washington, DC. States will receive 100% federal match for the first three years, which phases down to 90% in 2020.

"Medicaid will also use a new definition of income in determining eligibility," says Ms. Solomon. The challenge, she says, is developing a method that allows states to submit claims for federal matching funds at the appropriate matching rate for newly eligible beneficiaries, yet does not complicate the process of determining eligibility.

Alice Weiss, program director of the National Academy for State Health Policy in Washington, DC, says that states will need to accurately group Medicaid enrollees into two "buckets." These are "newly eligible," she explains, and those who would have been eligible for Medicaid prior to the Patient Protection and Affordable Care Act (PPACA)'s enactment.

This is necessary in order for states to claim the higher federal financial participation (FFP) rate for newly eligible individuals, explains Ms. Weiss.

"Errors in calculating the newly eligible group poses significant risks for states," says Ms. Weiss. "If states underestimate the number of individuals eligible for the higher match rate, they are leaving federal dollars on the table. If they overcount, they will likely have to repay the extra funds."

State efforts to accurately count newly eligible individuals are complicated by the fact that the PPACA directs states to use the simplified, modified adjusted gross income-based eligibility rules and processes for most Medicaid enrollees, adds Ms. Weiss. "This may make it harder for states to determine, after individuals are enrolled, whether they would have been eligible under prior Medicaid rules," she says.

Avoid duplicative process

"Concerns have been raised that states will have to determine eligibility twice — once using old rules, and then again using new rules — in order to determine whether an applicant would be eligible under the old rules," says Ms. Solomon. "Such a duplicative process would be extremely burdensome for applicants — and for states."

The good news, says Ms. Solomon, is that a duplicative process can be avoided. The PPACA provides that states will develop an equivalent income standard for their current income level using the new rules, which will apply to Medicaid, she explains.

States can then determine whether an applicant's income falls below this equivalent income level, which would make the applicant eligible under old rules, or is above that level and below the new income standard of 133% of the poverty line, says Ms. Solomon. In this case, the applicant would be a newly eligible beneficiary, allowing the state to claim the higher matching rate, she explains.

"In this way, the state can determine an applicant's income just once, using the new rules," says Ms. Solomon.

Danielle Holahan, co-director of United Hospital Fund's Health Insurance Project in New York City, says, "The vision of a single national eligibility standard at 133% FPL is complicated by the need to track the groups who are currently and newly eligible for Medicaid."

Ms. Holahan adds, however, that this is not as big an issue for New York as other states, because few individuals — only childless adults with income 100% to 133% of FPL — will be newly eligible for Medicaid. "Further, as an 'expansion state,' New York will get an enhanced FMAP [Federal Medical Assistance Percentage] for our currently eligible childless adults, in addition to our newly eligible childless adults," says Ms. Holahan. These FMAPs differ in 2014 through 2019, but then align at 93% in 2019 and 90% in 2020.

"For the interim years of 2014 through 2019, there will be a need to track these groups for the purposes of determining which match we'll get," says Ms. Holahan.

Other states face a bigger challenge in this area, Ms. Holahan explains, because they will have to manage a variety of newly eligible populations along with their current eligibles.

"There could be the need to maintain questions on the application form for the purpose of tracking current eligibles that states would otherwise eliminate in an effort to streamline the application and enrollment process," adds Ms. Holahan.

Assets are issue

About half of states still have an asset limit for parents, which Ms. Solomon says presents an added challenge. Beginning in 2014, assets will not be considered in determining eligibility for most Medicaid beneficiaries.

"An additional question, then, is whether states will have to con-

sider assets for those applicants whose income is below the state's current income eligibility levels, in order to make a final decision on whether these individuals would have actually been eligible under the state's old rules," says Ms. Solomon.

This extra step could be avoided, Ms. Solomon says, by sampling a state's caseload to determine what percentage of beneficiaries with incomes below the state's old eligibility standard have assets above the state's old limit, and therefore would not have been eligible under the state's old rules — even though their income was below the old income standard.

"Sampling would avoid having to ask unnecessary questions about assets of most beneficiaries," says Ms. Solomon.

Time and budget constraints

Ms. Weiss says that to avoid losing out financially, states will have to develop back-end systems that can accurately categorize individuals after they are enrolled into the "newly eligible" and "previously eligible" buckets.

"States will need further guidance from CMS [the Centers for Medicare & Medicaid Services] on how they can comply with the streamlined enrollment requirements, while at the same time getting the data they need to make an accurate eligibility grouping, so they can accurately claim the higher match rate for newly eligible individuals," adds Ms. Weiss. States are mandated to use a simplified application form and minimize documentation burdens for applicants, she explains.

"One model CMS might want to consider would allow states to perform an audit on a smaller sample of beneficiaries to estimate the percentage of newly eligibles based on that sample," Ms. Weiss suggests. This might help states avoid having to create an entire new system that determines eligibility groupings on the "back end" once an individual is enrolled, she says.

States face major challenges in developing systems that can perform back-end eligibility analyses, and obtaining the data they need to make an accurate eligibility grouping, says Ms. Weiss. This is particularly challenging, given the new limits on how much data can be collected from individuals in the application process, she notes.

However, Ms. Weiss says that "a far greater challenge" for states is budget constraints, which are limiting their capacity to invest in Medicaid, and the aggressive timeline for implementing system changes. Ms. Weiss points to a joint guidance from CMS and the Office for Consumer Information and Insurance Oversight, proposing a higher match rate for eligibility systems improvements. "This could provide a much-needed shot in the arm to boost state efforts to develop new systems," she says. "However, states still face significant time constraints to plan and implement complex and substantial system changes."

If states fail to implement this eligibility grouping accurately, says Ms. Weiss, they risk missing out on the opportunity to simplify the eligibility and enrollment process that the PPACA provides.

Also, while states risk either leaving much-needed federal dollars on the table for newly eligible populations, or having to repay the federal government if they overestimate, says Ms. Weiss, "there is also an important pitfall for individual enrollees if states don't get the 'newly eligible' determination right."

Newly eligible individuals must receive either benchmark or benchmark-equivalent coverage, explains Ms. Weiss, which provide less comprehensive benefits than standard Medicaid benefits.

"For individuals who are inappropriately classified as newly eligible, they may be wrongly denied access to a more comprehensive benefit package," says Ms. Weiss.

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HIEs are opportunity for better value

Brian Osberg, Minnesota's state Medicaid director, says that the agency was "a bit surprised and pleased by how much emphasis the Office of the National Coordinator for Health Information Technology placed on HIE [Health Information Exchange]," as a result of the Health Information Technology for Economic and Clinical Health Act [HITECH] legislation.

"We think that there is certainly an opportunity to improve the value of the health services we are providing," says Mr. Osberg.

Minnesota plans to use its grant planning funds to develop its Health Information Technology plan and to develop the infrastructure to administer the incentive payments to Medicaid providers for the "meaningful use" of electronic health records (EHR), reports Mr. Osberg.

Mr. Osberg says that Minnesota Medicaid is currently waiting for the Office of the National Coordinator to approve its plans. "We have been quite involved in HIT development for some time," he says. "We are expecting they will be supportive of

the approach we are taking."

The Minnesota Department of Human Services is a cosponsor of the Minnesota HIE. "We committed resources to form this organization about three years ago, because we thought it was a good business decision. This was all long before the HITECH legislation," notes Mr. Osberg. "We had already made a commitment to be involved."

Mr. Osberg says that he believes the Minnesota Department of Health has put together a strong grant application, which emphasized the role of the Minnesota HIE as a "key player in what we call a Health Information Organization. This will be the entity that is going to facilitate the exchange of clinical information. We quickly realized that this was going to be our best business model."

Incentives are key

Mr. Osberg says that another key piece of HITECH is the role of state Medicaid agencies in federal electronic health records incentive payments. "We're not going to be ready for the first cycle, early in 2011. It will be later in 2011 before we have all this ready to go," says Mr. Osberg. "We're going to do it as soon as we can, but we also want to do it right."

There needs to be a formal infrastructure in place in order to make the incentive payments, explains Mr. Osberg. "Providers will not be penalized, because if they meet the 'meaningful use' provision, they will get paid for the entire period of time. We have made that known to our providers."

The department is now waiting for further guidance on how to correctly identify providers who meet the criteria for incentives. "We are already bringing on staff to do this. It is a major priority for us," reports Mr. Osberg. "Our providers would be eligible for a lot of money, and on the Medicare side, of course, they will be subject to penalties. So, we want to do everything we can to make sure they are successful."

Mr. Osberg says, "In our minds, what the electronic health record really does is facilitate health care reform. This will allow providers to be more effective, in terms of managing health care costs and improving quality."

The incentive payments will result in providers being more accountable for the financial and quality sides of health care, says Mr. Osberg.

"This is not going to be sufficient, though, because our clients also interact with long-term care services, social services, and behavioral health services," he says. "We need to go beyond the acute care system, and get this connected with other health care providers and sectors."

For Minnesota Medicaid's HIE approach to be truly successful, Mr. Osberg explains, it has to go beyond providers exchanging clinical information. "It also has to be available to the client through personal health records," he says. "The HIE would be a conduit to keep the client in the loop. That is something that we want to do well." ■