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In This Issue

WA attempt to limit non-urgent ER visits is being challenged

Budget reductions for the 2011-2013 biennium in Washington state include a legislatively mandated limit on non-emergency visits to hospital ERs, reports **Jeffery Thompson**, MD, MPH, chief medical officer of Washington's Medicaid program.

As of Oct. 1, 2011, Medicaid will pay for only three non-emergency visits to the ER per client per year, says Dr. Thompson, with the fourth and subsequent non-emergency visits not covered by Medicaid.

"This new rule was added to the Health Care Authority's budget by the legislature earlier this year," says Dr. Thompson. "It was intended to save about $72 million in state and federal funds for the biennium, by rebalancing our eÃorts to improve access, quality and cost."

Medicaid clients who are approaching the third-visit limit will be notified by letter, says Dr. Thompson, and warned that they may be billed for additional non-emergency visits. He adds that the Health Care Authority is working with communities to reduce non-emergent ER use, and improve the use of the medical home in a variety of other ways.

Hospitals and communities are working on plans to reduce non-

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Oregon expects cost savings from primary care investment

The AÃordable Care Act (ACA) requires that state Medicaid agencies reimburse primary care providers at 100% of the Medicare fee schedule for two years, notes **Donald Ross**, manager of the policy and planning section at the Oregon Health Authority's Division of Medical Assistance Programs.

This provides for 100% federal funding match for the states on the diÃerence between their previous rates to primary care providers, and the Medicare fee schedule states will be paying during those two years, he notes.

Fiscal Fitness: How States Cope

"Essentially, the state Medicaid agency has an opportunity to give the primary care providers a raise, at no cost to our general fund," says Mr. Ross.

The ACA provides $8 billion over the two years to pay certain physician groups 100% of Medicare fee-for-service rates for certain evaluation and management codes associated with office visits for preventive care, screening and diagnosis in the primary care setting, notes Mr. Ross.

"What the Medicare fee schedule

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Cover story

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emergent ER use as part of a statewide quality strategy, he notes, such as having frequent ER users utilize a single pharmacy, primary care provider, and hospital.

Case managers assist clients with more than three non-emergent ER visits in finding a primary care provider, says Dr. Thompson, and standard guidelines for narcotic use in the ER guidelines are being distributed.

Almost $98 million was spent on 327,965 fee-for-service Medicaid ER visits in 2010, adds Dr. Thompson, and 11,140 clients out of a total 1.2 million used the ER for reasons on the non-emergent code list, of which only 1,000 were children.

The legislature originally calculated the savings in state funds at about $32 million, but legislators also wanted the rule to be implemented July 1, he adds. "That did not allow enough time for preparation, legal requirements or proper notifications of providers and clients," says Dr. Thompson.

The expectation is that care will be improved, says Dr. Thompson, because Medicaid clients with chronic care and associated illnesses will go to primary care providers instead of ERs. "This care will be more comprehensive, more aĀordable and treat more than just symptoms," he says. "It will foster better care in a medical home."

Efforts to stop plan

The day before the new rule was implemented, the state chapter of the American College of Emergency Physicians (ACEP) filed a lawsuit asking that the court issue an order blocking the rule. At press time, the case was still pending.

"Obviously, this comes from the fact that the state budget that has to be trimmed," says **Stephen Anderson**, MD, FACEP, president of ACEP's Washington chapter. "The Health Care Authority was told to cut $72 million over two years. They chose to go about doing that by coming up with this plan."

The state ACEP chapter was joined in its lawsuit by the Washington State Medical Association and the Washington State Hospital Association. More than 700 diagnoses are classified as "non-emergent," including chest pain, abdominal pain, miscarriage and breathing problems, says Dr. Anderson.

"Their message is 'Don't go to the ER with any of these diagnoses.' It's ridiculous, and clearly puts their population at risk," he says. "And the Medicaid population is one of the most vulnerable populations we have."

In addition, says Dr. Anderson, the state is violating the federal "prudent layperson" standard, a nationally recognized guideline for determining the need to visit an ER based on an average person's knowledge of health and medicine.

"The prudent layperson law has been in place for decades, and is there to protect everybody in this country," says Dr. Anderson. "It basically says that if you have an insurer, they can't retroactively deny your visit to the ER. We don't want to see this precedent start."

Washington ACEP presented an alternative to the state of assigning case managers to a much smaller population of about 1200 clients with more than eight ED visits a year, according to Dr. Anderson. He acknowledges that this approach would require an investment upfront to implement.

"But if our state budget continues to a be a problem, our approach has the ability to expand," says Dr. Anderson. "With the present pro-

posal, the only way to get more savings is to add more diagnoses to the list. It's a cheap way to do it. You just don't pay for the visit."

Dr. Anderson notes that other state Medicaid programs have made changes to reduce ER utilization, such as Medi-Cal, California's Medicaid program, but its list of 200 diagnoses was approved as non-emergent by ACEP.

"Other states have lists, but they have never tried to block the prudent layperson standard," he says. "The 700 diagnoses were put on the list only because of the economic price tag they carried with them."

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North Carolina targets high utilization of ERs

Washington Medicaid's plan to limit non-urgent ER visits to three a year is being watched "with great interest," says **Randall Best**, MD, JD, chief medical officer for North Carolina's Division of Medical Assistance. "It's a hot topic in pretty much all the states right now."

According to Dr. Best, eĀorts to limit ER utilization in Medicaid are nothing new, but have been brought to the forefront this year due to budget shortfalls. "This is a tough budget year, so everybody is saying if people weren't going to the ER, everything would be fine," he says. "That is probably a bit of a simplification."

Individuals who get routine medical care at the ER diĀer from those who go to primary care physicians, explains Dr. Best, because they often present with a combination of chronic pain syndromes, substance abuse and behavioral health issues. "All of these conditions are difficult to manage," he says. "Their diagnoses often look simple, but what they present with is quite a bit diĀerent."

A patient's ear infection diagnosis doesn't tell you that he or she also has serious mental illness, notes Dr. Best, and while a sore throat diagnosis may seem non-urgent, there are rare times when it can signal a potentially fatal condition. "That is the problem with the claims data approach," he says.

While Medicaid programs are not required to provide unlimited services of any type, and all would like to reduce non-urgent ER visits, the problem is that the diagnosis is made retrospectively, says Dr. Best. "My background is in emergency medicine, so I probably look at a this a little diĀerently than most Medicaid directors," he adds.

The Emergency Medical Treatment and Labor Act is based on whether a "prudent layperson" believes he or she may have a life-threatening emergency, adds Dr. Best, and severe pain may meet this criteria. "To me, to not reimburse the providers isn't really utilization management. It's more financial management," he says.

Targeting frequent flyer

Like Washington state's Medicaid program, North Carolina has made changes to reduce non-urgent ER utilization, but has taken a diĀerent approach, says Dr. Best. "We have not gone down the road of trying to reimburse for just a certain number of ER visits," he says. "We are trying to figure out what the root cause is for the visit."

Instead of casting a wider net to include individuals who go to the ER six or seven times a year, says Dr. Best, the focus is on a much smaller group with far higher utilization. "We are focusing on patients with massive numbers of visits. We had one patient who had 203 visits in a calendar year," he says. "I think that everyone would agree that is less than optimal care."

To get the care of this group managed more appropriately, the Medicaid program will work with its managed care partners, Community Care of North Carolina (CCNC), which three-quarters of Medicaid clients are enrolled in, says Dr. Best.

Each of CCNC's 14 primary care networks will work with individual Medicaid clients to see if they need referrals for behavioral health or chronic pain, and also to determine why they use the ER so much, says Dr. Best.

"It is a very case-by-case, labor-intensive process," he says. "If somebody is going to the ER six times a year, trying to get them down to four times isn't that easy. If somebody goes 100 times, getting them down to 75 is a lot more doable."

Reaching out to patients

Recently, North Carolina Medicaid looked at all patients with more than ten CT scans done at ERs in a single year, unrelated to trauma or malignancies, as a patient safety initiative. "A group of three of us called each patient. We didn't say, 'You need to quit going to the ER because this is costing a lot of money.' We told them there is a risk of cancer over time because of ionizing radiation," says Dr. Best.

Patients were instructed to report their previous procedures to their physicians, he adds, and were given referrals to care managers. "We have to walk a fine line. We don't want patients refusing necessary tests because of the fear

of radiation," Dr. Best explains. "But patients with chronic pain complaints probably don't need as many CT scans as they're getting."

The same approach may be taken with the Medicaid program's most frequent ER utilizers, says Dr. Best, with care managers calling to inform them that obtaining routine care in the ER isn't the best way to get care, and to ask them why they use the ER so often.

A patient may go to the ER even though no emergency exists because he or she can't get in to see a primary care physician, has a mental illness that isn't being addressed, or to obtain pain medications he or she is addicted to, says Dr. Best. "Every patient is diĀerent. There is not really one easy answer to that," he says.

While private payers can discourage ER use with high copays, this is not the case for Medicaid programs, adds Dr. Best. "If Blue Cross feels like people are using ERs too much, it's very easy for them to put in a $250 copay to change that behavior," he says. "But with Medicaid, any sizable copay will probably not looked at with favor by [the Centers for Medicare & Medicaid Services]."

Even if a small copay such as $3 was added, Dr. Best says that many Medicaid patients wouldn't pay it, resulting in decreased reimbursement to providers.

"There are a lot of unintended consequences with copays," he adds, noting that North Carolina Medicaid has a copay for office visits but not ER visits. "So that's a perverse disincentive to see the physician, which is something we will look at. Maybe we don't need a copay in the outpatient setting, either."

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Fiscal Fitness

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will be for these services in 2013 is something we do not know at this time. So the diĀerence between Oregon 2009 rates and 2013 Medicare rates is an unknown," says Mr. Ross. Therefore, he says, it's difficult to project how much the total increased payments to primary care will be, and how much it would have cost without the additional federal funding.

"To put it in perspective, though, the current primary care Medicaid conversion factor for Oregon is $27.82, and the current Medicare conversion factor is $33.98," says Mr. Ross. "That is a diĀerence of 22%, so the increase will be substantial."

The state will use this temporary additional federal funding to leverage increased and improved access to primary care services, says Mr. Ross, such as routine diagnostic screening and preventive care, in a way that is sustainable beyond the two years the temporary funds will be available.

Provider rates were reduced 7% as of August 2011, adds Mr. Ross, with the exception of primary care services. "These reductions, and many others to other provider types and programs, have been necessary to meet the legislatively approved budget for the 2011-2013 biennium," he says.

The state will benefit from the additional federal funding during the last six months of the biennium, from January 2013 to July 2013, says Mr. Ross, but most of the benefits will be experienced during the following 2013-2015 biennium.

"We did not cut services in our last round of reductions," adds Mr. Ross. "We are achieving all our reductions in spending through rate reductions, utilization controls, care integration and coordination, and like strategies."

The goal is to do more than just pay an increased rate to primary care providers, adds Mr. Ross, and instead, to collaborate with them on new payment methodologies, rewards for reaching quality targets in evidence-based primary care, and other incentives for better access to preventive care and increased wellness in the population.

"If we can reduce costs in other areas by reducing utilization in more expensive settings, and reducing the incidence of acute health-related problems because of early screening and preventive care, we have a chance to divert additional funding to primary care," says Mr. Ross.

Lower expenditures

"Our goal is to experience the cost savings that results from a healthier population," says Mr. Ross. "We look forward to better primary care access, resulting in Medicaid recipients whose health issues are addressed earlier."

Though Mr. Ross says there aren't any estimates for the amount of expected savings, he notes that some of the state's planned approaches have already been implemented in other parts of the country.

"The impacts have been documented in various settings, ranging in size from one patient-centered primary care home to fully integrated health systems that serve an entire community," says Mr. Ross. "There is enough evidence of cost reduction out there for the leadership in the state of Oregon to have made the decision we should go in this direction."

The goal is to move away from delivery systems that deliver care in fragmented and uncoordinated ways, says Mr. Ross, and payment systems that reimburse more for more volume of services provided,

instead of reimbursing for value and outcomes.

"That generates lower expenditures on the kind of care that must be delivered when preventable serious conditions and acute events occur," says Mr. Ross. Most of the savings will come from reduced hospitalizations, ER visits, and surgical procedures, he predicts.

"We believe the cost savings will be substantial. We also believe it will be higher quality care for the population," says Mr. Ross.

Workforce shortage

There are not enough primary care providers in many communities of many states, says Mr. Ross, and those that do exist are busy each day caring for individuals with Medicare, commercial insurance, or employer-sponsored coverage, all of which pay higher rates to providers than state Medicaid agencies and managed care plans do.

"The provider is left with tough decisions about practice mix and how much Medicaid, if any, they can aĀord to see," says Mr. Ross. "If we can increase the rate we pay primary care for Medicaid to Medicare levels, we should see some increased participation in our programs and improved access to primary care."

However, the shortage of primary care providers still needs to be addressed, he says. Another challenge is how to define primary care, and how to operationalize fee schedules for providers that pay one specialty a diĀerent rate than another specialty, says Mr. Ross.

"For example, how do you set your claims and benefit systems up, and set providers up in those systems, so that a code billed by a family doctor pays a higher rate than the same code billed by a neurologist?" he asks.

Primary care must be defined in those systems by both the type of provider, and the type of care, says Dr. Ross. "The legislation and rules have given us some guidance on this, but we still need to make sure our systems will adjudicate these claims correctly," he says. "The most significant opportunity for us is that we do have some additional federal funding from the ACA to accomplish this."

This means that ideas won't "die on the vine" because of a lack of funding to implement them, says Mr. Ross. "Instead, they have a chance to actually bear fruit and build sustainable momentum in the transformation of our state Medicaid delivery systems," he says. "This can result in improved capacity for the growing expansion populations in our future."

Mr. Ross says that he expects to see increased participation of primary care providers in the Medicaid programs, and more practitioners who see Medicaid business as a fiscally viable component of a healthy private practice.

"We have this funding for two years. When that time is over, we must have more primary care providers available for the expanding population," says Mr. Ross. "We must have methods for compensation in Medicaid that will sustain that increased access beyond 2014."

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Is it legal for Medicaid to limit non-urgent ER visits?

As a general rule, courts have upheld limitations on Medicaid reimbursements for services, as long as the services are "sufficient in amount, duration, and scope to reasonably achieve their purpose," according to **Laura Hermer**, JD, LLM, an assistant professor of health policy and bioethics at the University of Texas Medical Branch in Galveston.

"A state Medicaid agency can put reasonable limits on a service based on utilization control, as it would appear Washington has attempted to do," says Ms. Hermer, noting that courts have upheld state limitations on coverage of monthly physician visits and annual hospital inpatient and outpatient days.

The Washington chapter of the American College of Emergency Physicians (ACEP)'s lawsuit against Washington's Health Care Authority claims that emergency care is treated diĀerently under the law from other Medicaid services in several crucial respects, says Ms. Hermer, and thus may not be able to be limited, at least for certain Medicaid populations, in the way the state seeks.

"The lawsuit includes a mix of state and federal law arguments," says **Erin C. Fuse Brown**, JD, a visiting assistant professor and visiting fellow in ethics and health policy at Arizona State University's Sandra Day O'Connor College of Law in Tempe.

The broader legal issue is whether these types of ER visit limitations or reductions in payments for non-emergency ER visits violate federal Medicaid requirements, says Ms. Fuse Brown, and whether lawsuits by providers or patients can seek to enforce these Medicaid requirements.

As state Medicaid agencies struggle to reduce unnecessary ER

use through coverage limitations and co-payments, the boundaries of permissibility will likely be challenged in the courts, according to **John D. Blum**, JD, MHS, a John J. Waldon research professor of law at Loyola University Chicago School of Law. "But, reduction in inappropriate ER utilization is essential to programmatic reform," he adds.

Reasons for ER use

The lawsuit's contentions that the state can't restrict ED coverage for children and people covered by a Medicaid managed care organization, at least not without a waiver, may be correct, says Ms. Hermer.

"But whether or not the suit is ultimately successful, Washington's policy is a poor one," she says, acknowledging that Medicaid populations generally obtain care in ERs for non-emergent conditions more often than patients with other forms of coverage.

Medicaid beneficiaries often have a more difficult time finding providers than people with other forms of coverage, Ms. Hermer explains, and are more likely to have low-wage, low-skill jobs that they risk losing if they take time oĀ to see a doctor.

"The ED, however, has to take them, and is open both nights and weekends," she says. "EDs also provide 'one-stop shopping,' so patients don't have to take further precious time oĀ from work or caregiver activities to obtain tests and studies, or see specialists."

It's not surprising that Medicaid patients use EDs as a regular source of care, says Ms. Hermer, but Washington's policy doesn't make it simpler for beneficiaries to obtain non-emergent health care from regular providers. "Rather, it merely squeezes both Medicaid patients and emergency providers further than is already the case," she says.

"Prudent layperson" is key

The challenge to the Washington state ER policy centers around whether the three-visit restriction violates the federal "prudent layperson" standard that defines an emergency, according to Mr. Blum. "Bona fide emergencies, under federal and state law, must be covered by fee-for-service and managed care Medicaid," he says.

One of the lawsuit's claims is that the new policy conflicts with federal rules that require Medicaid managed care plans to pay for all emergency services needed to evaluate and stabilize emergency conditions, says Ms. Fuse Brown.

These are defined from the point of view of what a prudent layperson would think is an emergency condition needing immediate medical attention, she adds.

"The rules go on to say that Medicaid managed care entities may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms," says Ms. Fuse Brown.

While federal law requires Medicaid managed care plans to provide reimbursement for emergency services using the "prudent layperson" standard, Washington's new rules would mean that reimbursement would be barred for some conditions based on discharge diagnoses, notes Ms. Hermer. "As such, Washington's rule is at odds with federal requirements for Medicaid managed care plans," she says.

Most of Washington's Medicaid population is covered by managed care organizations, yet Washington's Health Care Authority doesn't except these beneficiaries from the rule, adds Ms. Hermer.

Additionally, she says, care for children under Early and Periodic Screening, Diagnosis, and Treatment programs can't be subject to limitations such as the one Washington is imposing on emergency services, yet children aren't excluded from the rule.

While issues about compliance with state administrative procedures are raised, and a federal supremacy clause challenge is made, Mr. Blum says "the heart of the case is more akin to [Emergency Medical Treatment and Labor Act] litigation that raises questions about whether a given scenario constitutes an emergency requiring appropriate action."

Underlying tension

"The legal issue underlines a tension in competing policy concerns," says Ms. Fuse Brown. On the one hand, she says, state and federal laws tend to define emergency conditions from the perspective of a prudent layperson, based on the belief that a person who reasonably believes he or she has a medical condition should not be discouraged from going to the ER out of fear that the visit won't be covered.

On the other hand, states like Washington are struggling to deter people from going to the ER for conditions that are clearly non-urgent, or for chronic conditions that are better treated by primary care physicians or walk-in clinics, says Ms. Fuse Brown.

"In theory, the prudent layperson definition of covered emergency conditions already addresses those cases, because a prudent layperson should be able to tell that a sprained ankle is not an emergency," she says.

Washington's list of 700 non-emergency diagnoses appears to include conditions that a prudent layperson may reasonably believe to be an emergency, however, says Ms. Fuse Brown.

"If a person fears they broke their ankle, but in fact only suffered a serious sprain, should they be denied coverage for their ER visit to get an X-ray and rule out the broken bone?" she asks. "Or should they wait until they can be seen by their regular physician, even if means delaying treatment for what turns out to be a fracture?"

Ms. Fuse Brown says that "the looming and unanswered legal issue" is whether providers or beneficiaries have the ability to sue the state for policies that violate Medicaid rules.

She notes that the U.S. Supreme Court recently heard arguments in the case of *Douglas v. Independent Living Center of Southern California*, and is considering whether providers and patients have the right to sue states for Medicaid cuts that violate federal laws, when there is no such explicit right of action.

The state of California and the federal government argued that providers and patients have no implied right to sue to enforce the Medicaid laws, which is left to federal agency oversight, Ms. Fuse Brown explains.

"The providers and patients argue that they have the right under the Supremacy clause of the Constitution," she says. "This provides that federal laws, like Medicaid, trump conflicting state laws."

The outcome of the Douglas case will certainly aÃect Washington ACEP's arguments against the Medicaid ER visit policy, says Ms. Fuse Brown, "which, echoing the providers in Douglas, ACEP argues is unconstitutional under the Supremacy clause of the Constitution."

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Medicaid mental health spending uneven even within single state

Would you expect a New York Medicaid client to be able to access mental health service equally well, regardless of where he or she lived within the state?

"In a single state, you should have the same provision and coverage of services," says **Teresa A. Coughlin**, a senior fellow at the Urban Institute's Health Policy Center in Washington, DC. However, there was a significant amount of geographical variation in spending on mental health services even within an individual state, according to the February 2011 report, "New York Medicaid Beneficiaries with Mental Health and Substance Abuse Conditions."[1]

"That was somewhat surprising to us," says Ms. Coughlin, the report's lead author. "It raises some important issues for states about what is driving those diÃerences." The study didn't address whether outcomes were poorer in areas that were spending considerably less, she notes.

The report also showed that total mean Medicaid spending for beneficiaries with mental health conditions ($28,451) was nearly twice that of their counterparts without mental health conditions ($15,964).

This population is severely and persistently mentally ill, with both mental and physical health problems, and isn't in managed care, Ms. Coughlin notes, and so is very high-cost. "It certainly looks to be a population that could benefit by having coordination of services," she says.

States are increasingly targeting this population to improve efficiency of care, adds Ms. Coughlin, and need to look at both mental health and physical health simultaneously. Often, Medicaid clients with mental health conditions go to a mental health provider, but won't go to a doctor for their physical health problems, she notes.

"The providers are sometimes in diÃerent networks, and are not always talking to each other," she says. "Our data suggests that having primary care physicians in the same location as behavioral health providers could be a useful strategy."

Level of coverage uncertain

"There are plenty of challenges, and certainly some opportunities" for Medicaid mental health services currently, according to **Ronald S. Honberg**, JD, national director for policy and legal aÃairs at the National Alliance on Mental Illness in Arlington, VA.

The challenges involve the current economic and continuing state budget crisis uncertainty, he says, with eÃorts being made both at the state and federal level to control entitlement spending.

"Medicaid is the most important funding source for public mental health services. It tends to cover services that traditional insurance doesn't cover," says Mr. Honberg, such as rehabilitative services that individuals need which may not fall within a narrow medical definition.

"The problem is that virtually all

mental health benefits for adults under Medicaid are optional. The states can cover them, but they don't have to," says Mr. Honberg.

Mr. Honberg says that he expects that the newly eligible population in 2014 will include significant numbers of adults with serious mental illnesses. One concern, he adds, is that it doesn't appear states will be required to provide the same level of coverage for the expanded populations.

"If states adopt a very narrow medical model private insurance model, it might mean that the kind of services that might be covered in traditional Medicaid programs won't be covered," says Mr. Honberg.

"Myopic" budgetary thinking

Over the years, many states have expanded their mental health coverage with case management or home and community-based service options, he notes. States may cut back on these expansions due to economic pressures, says Mr. Honberg, compounded by the expiration of the 18-month increased Federal Medical Assistance Percentages in June 2011.

"We really worry about what that is going to mean with vital services for people with mental health illness," says Mr. Honberg. "We haven't seen a lot of states cut back so far, but it's pretty early." A lot will depend on the direction that state economies go, but the eĀectiveness of advocacy eĀorts will also play a role, says Mr. Honberg, especially by demonstrating that mental health benefits save money in the long run by reducing unnecessary hospitalizations.

"It's well-documented that when you don't provide people with interventions when they most need those services, it just leads to longer term costs down the road," says Mr. Honberg.

The problem is that those costs may not be in the Medicaid program, notes Mr. Honberg, and each agency has their own bottom line to consider. A state may save money in its mental health budget, but end up spending more in its correctional budget, he says, and similarly, the eĀect of increased ER visits may not immediately be seen in the state mental health budget.

"Basically, you are robbing Peter to pay Paul," says Mr. Honberg. "During times of economic desperation, we tend to become more myopic in our budgetary thinking."

The goal is to get key policymakers to understand that all of these costs are part of the same "budget umbrella," says Mr. Honberg. "A sound fiscal strategy ought to look not only at the immediate impact on the mental health budget, but also the impact on law enforcement, correctional and emergency services."

REFERENCE

1. Coughlin TA, Shang B. New York Medicaid beneficiaries with mental health and substance abuse conditions. 2011: Medicaid Institute at United Hospital Fund, New York.

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Staffing shortages present obstacle to new access regs

Under a proposed rule published in May 2011 from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies would have to review access to a subset of Medicaid-covered services every year, and review access to every Medicaid-covered service at least once every five years.

This is "well-intended, but couldn't come at a worse time for states," says **Stephanie A. Davis**, CPA, national practice leader for Mercer's Phoenix-based Government Human Services Consulting division.

States already face severe budget challenges, limited ability to revise eligibility rules, and shortages of the necessary staĀ to respond to the many new requirements of the AĀordable Care Act (ACA), she notes.

"This rule could have the eĀect of delaying states' abilities to address changing economic situations in a timely manner, because of time-consuming and costly prerequisites for state plan amendment submissions," says Ms. Davis.

Although the proposed rule identifies required components of an access review, determining how a state actually demonstrates access will be a time-consuming challenge, according to Ms. Davis. "For states looking to make changes to their fee-for-service provider rates, it will be one more area to address," she says.

Performing access reviews before making rate reductions may make it difficult for states to manage their program in a timely and eĀective manner, adds Ms. Davis.

If the rule applies to services delivered through home and community-based programs, this is a large number of services for which there may be no commercial or private access comparisons readily available, she explains. "State resources are stretched thin, and

this will tax them even more," Ms. Davis says. "The cost and complexity of the rule may be underestimated."

"Very serious constraints"

Medicaid directors make difficult decisions when the amount of money to do "everything that everyone would like" falls short, says **Matt Salo**, executive director of the National Association of Medicaid Directors in Washington, DC.

"To a person, they are all dedicated to providing the best health care to the most people possible, with very, very serious constraints," he says. The decision comes down to cutting people oĀ the program, eliminating vital services that clients may rely on, or cutting provider rates, says Mr. Salo, noting that while procedures to monitor access vary by state, every state has these in place.

"What the regs do is say, 'That's not good enough. You have to undertake a very labor-intensive, one-size-fits-all approach to prove to CMS that access is not a problem," says Mr. Salo.

If a state is looking to lower provider rates, "this will probably stop them in their tracks," says Mr. Salo, because it sets out standards that are difficult or impossible to meet. "This may make providers happy because their rates aren't going to get cut. But it doesn't solve the problem of there not being enough money for everything."

Even states that aren't looking to lower reimbursement rates will still be burdened by paperwork and administrative hoops to jump through, according to Mr. Salo. "It will totally siphon away a significant workforce capacity to run the program as it is, to say nothing of trying to implement the ACA that is coming very quickly down the road," he says.

Already-understaĀed programs are grappling with eligibility and enrollment systems development, and fraud and abuse prevention, notes Mr. Salo. "When you divert significant resources to do something new, it's like squeezing down a balloon. It will only pop up somewhere else," he says.

Provider groups and beneficiaries are likely to support the CMS draft rule, says Mr. Salo, but this is taking an "ostrich in the sand" approach. "The longer-range strategy by some of them is to say that if we prevent the states from doing anything — changing eligibility, cutting reimbursement rates or getting rid of benefits — then they will be forced to raise taxes to pay for this."

The bottom line, says Mr. Salo, is that Medicaid programs are left with drastic, draconian options to balance their budgets. "State budgets are in trouble now, and are making these decisions now, but 2014 is going to make it worse," he says.

State budgets will not have sufficiently recovered and expenditures will skyrocket, says Mr. Salo, and 30 million people who were previously uninsured will have access to healthcare, either through Medicaid or the exchanges to be set up by states.

"It will no longer be just about whether Medicaid has an access issue, but whether there are enough providers to see all of these people, whether they are in public or private insurance," says Mr. Salo.

The needs of diĀerent states vary due to diĀerent mixes of managed care and fee-for-service, diĀerent systems, and diĀerent cultures, says Mr. Salo. "If there are specific states CMS thinks have specific problems with access, deal with them," he says. "Don't set a 'one size fits all' trap that catches all 50 states. That is not helpful."

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Resources are issue with CMS' Medicaid claims audit program

A new Medicaid recovery audit contractor (RAC) program will help strengthen the integrity of the Medicaid program, according to **Xiaoyi Huang**, JD, assistant vice president for policy at the National Association of Public Hospitals and Health Systems in Washington, DC. "That being said, we need to be cognizant of program integrity eĀorts that places undue burden on providers," she cautions.

According to the final rule from the Centers for Medicare & Medicaid Services (CMS), states must implement Medicaid RACs by Jan. 1, 2012. The RACs will search for fraud, waste and abuse in the program by reviewing past claims that already have been paid, with auditors paid based on the percentage of funds they recover that were paid inappropriately.

The Department of Health and Human Services estimates that Medicaid RACs will save the program $2.1 billion over the next five years, of which $900 million will return to states. However, Ms. Huang argues that CMS could have made the program better in several respects, such as requiring RACs to hire auditors with

knowledge of the details of the state Medicaid plan.

Given that the Medicaid program is highly complex and very state-specific, many issues could be open to interpretation, including coverage of benefits, explains Ms. Huang. "Without someone with expertise in and knowledge of the details of the state Medicaid plan, the Medicaid RAC should defer to state's interpretation where opinions diÃer," she says.

Another concern is that providers will be burdened in trying to meet the needs of multiple Medicaid auditors, says Ms. Huang, noting that the final rule states that a RAC should not audit claims that have already been audited or that are currently being audited by another entity.

"When another Medicaid auditor's scope overlaps with the Medicaid RAC's scope, then the state should not need to contract with a RAC to complete its audit," says Ms. Huang.

No significant recoveries

Kelly Shropshire, director of Oklahoma's Program Integrity and Accountability, says the fiscal impact of the new program is unknown at this time. "We have yet to implement the RAC program, nor can we pull from other state Medicaid program experiences. The program is still in its infancy and no outcomes have been realized," he says.

However, Mr. Shropshire notes that other recent federal audit initiatives, such as the Medicaid Integrity Contractors and the Medi-Medi program, which analyzes data from both the Medicaid and Medicare claims processing systems, have been established in Oklahoma for approximately two years.

"We have yet to see any recoveries at this time. While this will change over time, we do not expect to see any significant financial recoveries from these programs," says Mr. Shropshire. "Certainly, some benefit is achieved from the sentinel eÃect of having these oversight programs, but quantifying such is an estimate at best."

The RAC contractors are specialists in recovery of inappropriate payments and have had success in the Medicare program, adds Mr. Shropshire, but whether they will be successful in Medicaid remains to be seen. "Whether they will be successful in states with existing strong program integrity programs like Oklahoma is even more difficult to predict," he adds.

Inadequate staffing

The Oklahoma Health Care Authority is responsible for provider appeals regarding identified overpayments, says Mr. Shropshire, and depending on the volume, this could be very burdensome on the agency's legal division.

"Coordination of these audits will be yet another entity that staÃ will have to work with, to ensure that no duplication of eÃorts are occurring," he says.

The agency would be interested in an exemption from the Medicaid RAC program, according to Mr. Shropshire. "CMS has made it very clear that exemptions will be few and far between," he acknowledges, adding that the agency's existing program integrity program and low PERM error rates could merit such consideration.

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Volume of referrals, appeals are concern with RACs

A state plan amendment submitted by North Carolina Medicaid to the Centers for Medicare & Medicaid Services (CMS) to participate with the Medicaid recovery audit contractor (RAC) program has already been approved, and a request for proposal will be released shortly, reports **Brad Deen**, a spokesperson for North Carolina Division of Medical Assistance (NCDMA).

"Medicaid RACs were not intended to totally replace any state program integrity or audit initiatives or programs," says Mr. Deen. "North Carolina sees this as a way to enhance its eÃorts. It oÃers a different way to leverage resources and financing of program integrity eÃorts."

Inadequate staffing

The state has a year to attempt to recover an overpayment identified by a RAC from a provider, except in cases of fraud where the time period may be longer, notes Mr. Deen, and the federal share must then be returned regardless of whether the overpayment is recovered.

"However, if a determination is overturned on appeal, the NCDMA can request a refund of the federal share," adds Mr. Deen. The main impact of the CMS requirements will be on the state's DMA hearing office appeal processes for providers to dispute adverse determinations made by Medicaid RACs, he

says.

"Our state currently does not have adequate staffing resources to handle the possible influx of provider disputes," says Mr. Deen, explaining that North Carolina's appeal process for providers is more extensive than what is federally required.

Providers can request a redetermination when they are dissatisfied with the overpayment decision, he explains, and a redetermination must be submitted within 30 days to prevent oĀset on day 41. To comply with the requirement that the Medicaid RAC refer suspected cases of fraud or abuse to North Carolina Medicaid in a timely manner, Mr. Deen says that NCDMA will need to review findings for accuracy and forward these to the state's Medicaid Fraud Investigation Unit.

"Due to the expected increase in referrals, this could be a staffing and resource issue," says Mr. Deen. The Medicaid RACs must review Medicaid claims with a three-year maximum claims look-back period submitted by providers to NCDMA of services for which payment may be made under the state plan or a waiver of the state plan to identify overpayments and underpayments, he says.

"This will place additional constraints on DMA sections to obtain timely claims data reports for our RAC vendor review," Mr. Deen says. "The alternative will be to give RACs direct access to paid claims and not run the request through the Medicaid Data Section. This will change the business flow."

Possibility of savings

If the state pays RAC fees on an identified overpayment, and the provider prevails at any stage of the hearing process, RAC would be required to return any portion of the fee that corresponded to the amount of an overpayment that was overturned at any level of appeal, notes Mr. Deen. The appeals process can take over a year, he says, and North Carolina already has an extensive provider appeal process.

"The expected increase in appeals will add to the work load," he says. "A RAC would go unpaid for all its cases in the initial years while providers exhausted their appeal rights."

NCDMA has an obligation to coordinate auditing eĀorts to reduce the overburdening of Medicaid providers, adds Mr. Deen, and also to ensure that RACs do not duplicate or compromise the eĀorts of other entities performing audits.

North Carolina already has a post-payment review process in place with contracts working oĀ contingency, reports Mr. Deen, and the department has seen a marked increase in recoupments.

"So there are greater opportunities to increase savings through collection — if providers have not gone out of business or gone bankrupt," he says. "Otherwise, the RAC eĀorts could end up costing the state money." ■

Medicaid savings visible in real time via website

New York state's Medicaid Visual Data Mining System allows state officials and policy makers to track the results of savings initiatives in real time, via a spending tracking website, according to **Morris Peters**, a spokesperson for the Division of Budget. *(To view the site, go to http://www.health.state.ny.us/health_care/medicaid/regulations/global_cap/.)*

The state's Medicaid Redesign Team (MRT) made recommendations expected to save $2.2 billion by the end of fiscal year 2011, and to date $600 million in savings have been achieved, according to an October 2011 progress report.

"New York has the highest per capita Medicaid spending in the nation, by far," says Mr. Peters. "In his eĀort to control unsustainable growth, Governor Cuomo created the MRT. This brought together stakeholders from every area of health care, to help design a Medicaid system that increased quality while controlling costs."

The public participation in this process has been "unprecedented," according to Mr. Peters, with more than 2,000 e-mails submitted by individuals, Medicaid consumers, providers, associations, and state and local employees.

Many of the suggestions were included in a package of reform proposals that achieved the governor's Medicaid budget target of nearly $2.3 billion in savings, says Mr. Peters. The MRT monthly reports allow the public and officials to see the progress in reshaping Medicaid based on their input, he adds, and distributing information publicly holds both policymakers and involved stakeholders accountable.

"It ensures that individuals, associations, and officials have the information necessary to promote efficiencies and protect vital health care services," he adds. "It encourages health care providers to partner with the state in realizing savings, in an eĀort to avoid benefit cuts."

While overall Medicaid spending was reported annually through the state's Division of Budget, the new website allows

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reporting on an ongoing basis to a level of detail that has not been seen in New York state, says Mr. Peters.

"This model is expected to provide an example for other states of how to implement innovative solutions to manage rising health care costs," he says. "We have already been contacted by other states for insights on setting up a similar system."

"Very challenging"

"I don't know of any other website where a program has tried to document savings on Medicaid," says **Richard Kirsch**, a senior fellow at The Rockefeller Institute of Government in Albany, NY, adding that although the site is unique, he's skeptical it will be eĀective.

The site, says Mr. Kirsch, reflects the governor's approach to aĀect savings by restructuring Medicaid so quality care is provided more efficiently, instead of cutting specific programs.

"That's the right goal, and they are going to hold themselves to that with the idea that they are going to have a website that reports on it," says Mr. Kirsch. "But translating that in a way that is fair to the system is going to be incredibly difficult."

This is because the savings are coming from making system changes in the way health care is delivered, says Mr. Kirsch. "This the kind of savings that we need to see, rather than artificial savings that cuts benefits but transfers the cost to other people, or cuts what providers get paid," he says.

However, attributing savings to specific system changes is going to be "very challenging," says Mr. Kirsch, adding that the kind of savings New York Medicaid is trying to achieve are difficult to achieve over the short term.

"The temptation is going to be to say, 'We did this, and it saved this much money,' to demonstrate savings that may not really have been achieved, or to oversimplify complex problems in order to demonstrate success," says Mr. Kirsch.

The approach is clearly targeting the general public, adds Mr. Kirsch, to demonstrate the state is going to be transparent and accountable with Medicaid. Whether other states follow suit, he says, "will depend on how well this is received, and whether it helps make the program transparent or leads to a lot of confusion and name calling.'"

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