State Health Watch

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In This Issue

Demand rises for health care centers while the funding continues to drop

As the demand for services through federal health centers increases and Medicaid and other funding decreases, centers' ability to provide the same level of services or even remain open is threatened, according to a new report from the National Association of Community Health Centers (NACHC).

"How these trends will shape the future of the safety net and America's health care delivery system depends largely on the crosscurrents of policy changes under way at the state and federal level," according to the NACHC report. "Congress and national leaders are considering proposals that could dramatically restructure Medicaid. States are already enacting their own Medicaid cuts to trim budget costs, swelling the ranks of the uninsured. With eroding public insurance and the attrition of other revenue sources, health centers will not be able to meet the needs of a nation that, by all accounts, is gripped by a deepening health care crisis. The public health consequences of a crippled safety net will impact not just health centers alone, but also the rest of America's health care system. The loss of primary care providers will

See ***Centers*** *on page 2*

Georgia's Medicaid agency achieves significant increase in financial recoveries in fraud, waste

The Georgia Department of Community Health's Program Integrity Unit has increased its financial recoveries in fraud, waste, abuse, and overpayment cases from $2 million to $22 million a year by taking a law enforcement approach and using sophisticated data mining techniques.

Fiscal Fitness: How States Cope

Program Integrity director **Doug Colburn** tells *State Health Watch* one of the keys to the success his unit has achieved since he began directing it in December 2003 is that it reports to the department's general counsel rather than to the state Medicaid director, creating more of a law enforcement mindset.

The unit has 53 staff positions, including data analysts, clinical experts, and experienced investigators. It uses Thomson Medstat decision support tools, methodologies, and consulting to mine a five- to seven-year database of claims from all Medicaid beneficiaries.

Mr. Colburn has said the unit's primary goal is to "identify and respond to fraud and abuse within

See ***Fiscal Fitness*** *on page 4*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

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Centers

Continued from cover

cause racial and ethnic health disparities to soar, leading to more avoidable illness and increased mortality. Hospital emergency rooms, already challenged by long lines and uncompensated care costs, will be forced to care for a growing number of low-income and uninsured patients who will have no place else to go."

NACHC communications director **Amy Simmons** tells *State Health Watch* the report is the latest in a series looking at the role that health centers play in delivering care.

"We wanted to look at how Medicaid cuts impact patient care," she says. "We're already seeing some cuts with Section 1115 waivers. The trend has been that the waivers are used not to expand coverage or innovate delivery, but to make cuts, and we wanted to see the impact."

Health centers are in their 40th year, one of the last remaining programs from President Johnson's Great Society. They essentially are unchanged from how early health care leaders envisioned them — locally owned, nonprofit, and community-oriented health care providers that improve access to care for millions of low-income and medically underserved Americans.

Open to *all*

"No one is turned away regardless of their insurance status or ability to pay," the report asserts. "They are a medical home to 15 million patients who live in rural areas around the country."

According to NACHC, independent evaluations over the last 40 years have found that the care received at health centers is among the most cost-effective anywhere.

Health center patients represent one in seven low-income people, including one in four at or below the federal poverty line; one of every eight uninsured Americans, including one in five low-income uninsured; one in nine Medicaid beneficiaries; one in 10 minorities; and one in 10 rural residents.

"Health center patients are disproportionately low-income, uninsured, or publicly insured racial and ethnic minorities," the report declares. "Health center patients also suffer from poorer health than the general population."

The report notes that over the last several years, health centers have seen increases in the number of patients with all insurance types *except* for patients who rely on certain public insurance such as non-Medicaid expansion SCHIP and state-funded programs. Actually, the proportion of patients with other public insurance has been declining since 2001, according to the study, most likely linked to cuts in state-funded insurance programs and non-Medicaid SCHIP, although the number of Medicaid patients seen has increased.

Having an impact on the increase in total patients, many of whom are low-income, is the fact that most health centers experienced a growth rate of uninsured much higher than the national average of 8.2%. And many also experienced significant declines in the number of patients with Medicaid between 2003 and 2004. In the same time period, 587 health centers experienced a rise in the number of patients without insurance. More than 230 (26%) reported an increase of 20% or more. The association says even more troubling is that 314 health centers (35.6%) experienced a decline in Medicaid patients, and among those with declining rates of Medicaid patients, 60% also saw increasing numbers of uninsured patients.

The reports detailed Medicaid cuts in eligibility and new or higher cost-sharing arrangements for Minnesota, Rhode Island, Tennessee, Nebraska, North Carolina, and Massachusetts, and said the impact of the cuts "has been immediate and dramatic at health centers in each of these states and many others. Each of those states reported a decline in the total number of Medicaid beneficiaries served by health centers relative to all patients between 2002 and 2003 or 2003 and 2004."

Costs comparable to others

NACHC reported the cost of care at health centers is comparable to or even less than private, office-based doctors, even as the centers provide high quality care and enabling services to a growing number of patients. But between 2003 and 2004, costs per patient rose 5.3%, while the number of patients rose 5.9%. However, between 1999 and 2004, costs per patient grew slower than national health expenditures per capita over the same period, indicating that health centers have kept some costs down.

"The rising cost of care at health centers generally stems from three factors: rising costs of delivering health care, an increasing and disproportionately medically vulnerable patient population, and an increase in the number and type of services that health centers offer," the association said. "Soaring health care costs can be observed in every health care sector, and health centers are not sheltered from this reality."

While health centers on average have been able to generate enough revenue to cover their costs, operating margins have remained low. Even as nonprofit health care providers, centers rely on margins to ensure financial stability. Any surplus, which tends to be negligible in comparison to costs or revenue, can be used to care for more uninsured patients in the following year, or even to cover costs related to unexpected events such as public health outbreaks, natural disasters such as hurricanes and floods, and even disaster preparedness.

Over the last few years, health centers' operating margins on average have tended to hover around 1%, although margins were half that rate in 2003. Two in five federally funded health centers reported operating deficits last year. That compares to 36% of hospitals experiencing negative operating margins in 2003. Almost 15% of centers had operating deficits exceeding 10% of their revenue. And the health centers with zero and negative margins had higher growth in the number of low-income and uninsured patients than centers that reported positive margins. Moreover, they tend to collect less from Medicaid, Medicare, and other public insurance programs.

The association was quick to point out that health center operating margins are often lower than other provider types. For example, hospitals averaged a 3.3% margin in 2003, while health centers were 0.5% that year. At such low levels, NACHC said, a single unexpected event such as a disease outbreak, hurricane, snowstorm, or power outage, could easily put a health center in deficit, threatening its ability to provide comprehensive care in its community.

Given the constraints and challenges facing health centers, NACHC also looked at the adverse impacts of centers closing.

"Should a health center be forced to close," the report cautioned, "an entire community would be adversely affected by the termination of valuable public health services, such as immunizations, and the prospect of rising health care costs as a consequence. Already the percentage of Americans with a usual place to go for care and the percentage who assess their health as excellent or very good are on the decline. Thus, cuts in Medicaid that negatively impact centers are, in fact, penny-wise and pound-foolish, and access to primary care is important for the entire health care system. Even a small drop in revenue affects health centers' ability to serve more patients."

It is the association's assessment that Medicaid erosion, coupled with further attrition of other revenue sources, poses the most direct threat to the ability of health centers to meet the health care needs of their communities.

"Even as Congress and the administration plan to increase funding to support new health centers, sustaining diverse and dependable revenue streams for all health centers is essential if the program is to survive and continue its role in helping to meet the nation's most pressing health care needs," the report said.

Ms. Simmons tells *SHW* it's not clear what will happen to proposed Medicaid cuts in light of the health care needs of the victims of hurricanes Katrina and Rita. The impact will vary from state to state, she says, depending on what changes each state makes. She notes that the day major cuts to Tennessee's TennCare program were implemented, between 50 and 100 new patients showed up one health center in the state seeking appointments.

NACHC assistant director of state affairs **Dawn McKinney** tells *SHW* she expects centers will continue to pick up new patients among those who lose their Medicaid coverage or are uninsured.

"The point of our report is that we see the rate of uninsured

two to three times the national average," Ms. Simmons says. "It's a signal, much like a canary in a coal mine."

In addition, according to NACHC research and data analyst **Michelle Proser**, the number of low-income patients served by centers has increased four times the national average. She says Medicaid traditionally has represented 36% of health center revenue and thus those that serve a large number of Medicaid patients are especially at risk. The specific impact of factors contributing to financial insecurity, Proser says, depends on the environment in each community and state. ■

Fiscal Fitness

(Continued from cover)

the system and to assist providers with education and corrective action."

He said the unit uses the latest technology to detect and correct abuse and identify fraud; maintains strong relationships with other state and federal agencies that also identify and prosecute fraud and abuse; keeps communications lines open with professional medical organizations to more easily identify providers who abuse Medicaid; has developed a centralized information system that tracks cases from beginning to end; and strives for cost avoidance with corrective action, education, and prevention.

Thomson Medstat client manager **Marci Bennafield** tells *SHW* the decision support system Mr. Colburn's staff uses contains a user-friendly interface that works well in the hands of his trained investigators to identify potential fraud cases for follow-up. "It requires someone who knows what they are looking for," she says. "Georgia has skilled investigators who are strong in what they do."

Ms. Bennafield says the decision support system is used across the Medicaid enterprise for financial reporting and budget development, policy analysis, managed care monitoring, provider profiling, clinical quality assessment, evaluation of disease management programs, and other analytic initiatives. Some 14 states currently are using the Thomson Medstat system in their fraud work.

Thomson Medstat, which has worked with Georgia for about 10 years, also provides 30-40 specific fraud algorithms each year, small programs intended to generate a report or respond to a specific question that Mr. Colburn and his staff want to look into.

"Each dollar lost to theft or abuse is one less available for someone who really needs care," Mr. Colburn says. "By stopping fraud and abuse and concentrating on cost avoidance, we help save tax dollars and ensure that valuable health care services will be available for eligible recipients in the future."

Intentional deception

The unit defines fraud as an intentional deception or misrepresentation made by a person with the knowledge that it could result in some unauthorized benefit for himself or others. It includes any act that constitutes fraud under applicable federal or state law.

Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical practices, which result in unnecessary costs to the Medicaid program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. Member practices that result in unnecessary costs to the Medicaid/Georgia program or State Health Benefit Plan also are considered abuse.

Examples of fraud and abuse that the unit investigates include unreported income or insurance, Georgia recipients living out of state, drug-seeking behavior, incarceration, individuals receiving bills or explanations of benefits for services never provided, provider billing irregularities, over- or underuse of health care services and misrepresentation of credentials. Provider fraud could involve doctors, hospitals, nursing homes, home health, durable medical equipment, pharmacies, mental health facilities, laboratories, transportation, and dentists.

The unit has 12 investigators, half of whom are certified peace officers. Mr. Colburn tells *SHW* that because he had 10 years' experience in law enforcement when he became unit director, his first step was to identify inefficient business practices and start to build a better model.

"We tore the organizational chart apart and started over," he recalls.

Because there was no clear route for cases to follow, Mr. Colburn and his staff defined the needed information flow from complaint to resolution. As part of the law enforcement mentality, he says, each case is assigned a number so it can be tracked through the system. Case numbers are assigned at a central point before cases are handed out to investigators.

While staff with clinical expertise had been used to getting cases as they came in, Mr. Colburn moved them to the second phase of handling a case, sending each one first to an investigator because they can do a better job of interviewing and pursuing leads they receive. It is the investigators who have the initial contact with providers.

Once the investigators have developed a case to the point that it is ready to move forward, one or more staff members with clinical expertise is assigned to work with

the investigator. They will continue to work together until the case is resolved.

Mr. Colburn tells *SHW* the data produced by Medstat is the basis for all the cases developed. He tells providers he will not pursue allegations from disgruntled former provider employees unless a statistical analysis backs up the allegation.

The program had its rough moments as the changes were presented and implemented, Mr. Colburn recalls. "I can't say it's easy to change mindsets," he says, "because it wasn't."

But there have been enough success stories achieved in reacting to complaints that the unit is now moving into a second phase that involves mining data for trends that can be investigated proactively rather than waiting for a specific complaint to be filed.

"We're looking for cases and not waiting for them to come in," he says. "And we've seen some successes." One such new effort is a power wheelchair study that is looking at whether some medical device providers have been delivering wheelchairs but billing for more expensive scooters. The unit intended to send letters to those who have received the devices with a picture of each one and a request that they indicate which device they received. Down the road they also will be looking at medical necessity for scooters and wheelchairs.

"Such an effort requires a small resource investment compared to what we are likely to get out of it," Mr. Colburn explains.

Another new study involves ambulance runs that don't show a corresponding emergency room, inpatient, or outpatient treatment.

"You'd be surprised at how many of these pop up," Mr. Colburn asserts. "We're going to send out recoupment letters based solely on the data. Providers will be able to submit more documentation or ask for an administrative review."

Mr. Colburn and his staff also are starting to run trending reports, such as one looking at dentists who prescribe 30- to 60-day supplies of painkillers.

"Our goal is to get to the point that we are always proactively looking for cases," he says. "We then want to get to the point that prevention outweighs what we do reactively. We want to do more identifying trends so the claims system is working for us. Eventually, it will automatically suspend a claim and notify us when a billing seems suspicious."

While the unit had been something of a joke within the organization, with staff morale very low, Mr. Colburn says it has gone through a Cinderella-like change, in which it has gone from being the butt of many jokes to being taken very seriously and being called in early to provide input and consult on actions being considered.

"Agency executives wanted our buy-in to development of our Medicaid managed care process," he reports. "My staff feels a sense of empowerment and they're having fun at what they do."

Mr. Colburn says providers were shocked at first because they were used to being able to take advantage of the department's open-door policy and desire to be sure providers are willing to take Medicaid patients.

"Providers have come to recognize that we want to build up those who are good and honest and help those who have made a mistake," he says.

A by-product of the effort is an increase in accountability and an increase in self-reporting of problems. Mr. Colburn says he has adopted the federal approach in which providers know it is cheaper and easier for them to approach the unit if they think there is an issue in their claims billing rather than waiting for it to be found and taken to an enforcement action.

He says a next step will be to identify providers who have problems, such as billings that generate high denial rates, and offer them web-based training modules. They will track how the providers do after they have seen the training programs.

Asked for his recommendations to states that want to emulate his success, he offered three:

- Centralize the information flow by identifying business processes and tailoring the flow for an efficient process.
- Remove the program integrity unit from the Medicaid program. "You need a clear separation, while there still is a dovetail," Mr. Colburn says. "There can be conflicts of interest if program integrity reports directly to the Medicaid director.
- Develop an emphasis on data and reporting.

Mr. Colburn is proud of the success his unit has achieved but thinks cases will "explode when we are able to take data and go straight to recouping funds."

[Contact Mr. Colburn at (404) 206-6468.] ■

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Disease management ROI still is a tough sell

As state Medicaid programs, businesses, and health plans face increasing fiscal pressure, many are looking at disease management efforts as a way of saving money. But do such programs really save money? Is there a significant return on investment (ROI)?

A new study from Cornell University and Thomson Medstat says that while some of the programs can save money, hard evidence of their economic impact remains scant. Researchers led by Cornell University director of the Institute for Health and Productivity Studies **Ron Goetzel** reviewed 44 studies analyzing the economic impact and ROI for disease management programs. They found mixed results for programs targeting depression, diabetes, and asthma, and positive ROI for programs targeting congestive heart failure and multiple illnesses.

Mr. Goetzel said his research sheds light on disease management, but doesn't provide conclusive findings because relatively few economic analyses have been conducted. Also, he said, many of the studies that have been done involved a small number of subjects, and the programs that were analyzed varied significantly in format.

"Overall, there has been little scientifically rigorous research conducted to determine the financial impact of disease management," Mr. Goetzel said. "That's a concern because companies and government agencies have increasingly adopted disease management to control the cost of care for individuals with chronic medical conditions, a minority of the population responsible for a majority of health care spending. Despite the fact that disease management programs can deliver significant health benefits, employers and health plans still need a sound business case to continue offering these programs. More and better research on the business case is required."

Dr. **Sandeep Wadhwa**, who directs disease management programs for McKesson Corp., tells *State Health Watch* that while many people have criticized Mr. Goetzel's review, he believes it was "pretty well done" and accurately reported that ROI is difficult to determine because of the inconsistencies among programs and the fact that many studies have had relatively few subjects.

"I agree that more research is necessary," Mr. Wadhwa says. "I understand the tension between wanting to wait for rigorous studies and less significant data on techniques that can help payers save costs."

Two types of evaluation

Researchers have recognized that measuring the financial return associated with disease management is difficult because changes in health care costs over time cannot be assumed to be solely due to intervention in the population receiving disease management services.

Wilson Research principal **Thomas Wilson** wrote in a 2003 Academy Health issue brief on state disease management program ROI that many external factors can reduce health care costs. For example, he said, costs could have dropped in the disease management population because that group had been exposed recently to a heavily promoted new drug or because they experienced a change in benefit design, or a number of other external factors.

To address that problem, analysts must compare their disease management population to an appropriately chosen and measured reference population, allowing them to answer this question: What would have happened to the disease management population's health and health care resource use had it not received that intervention?

There are two general approaches to calculating ROI — direct and indirect. A direct assessment uses only primary data and must include at least one ultimate outcome metric available in the intervention and reference populations. To substantiate the ROI estimate, measures for at least one proximate outcome metric should be taken in both groups. If the clinical metrics change in the same direction as the financials, the financial impact probably was paralleled by a change in a clinical metric.

An indirect ROI assessment uses secondary data, such as a benchmark-type design. This analysis must include at least one proximate outcome metric, with the ultimate outcome inferred. An example of an indirect assessment would be imputed savings of lowering blood pressure over a five-year period, based on an acceptable formula for calculating savings. Mr. Wilson pointed out that indirect assessments are easily biased by both nonequivalence and lack of comparability.

The estimation of ROI requires comparing the cost differences between the intervention and reference groups on the ultimate outcome metric, divided by the disease management program cost.

"ROI is always an estimate and there are many biases that can influence it," Mr. Wilson said. "There will never be an ROI study that cannot be improved. Thus, the analysis should include a discussion of the study's strengths and weaknesses. … Given the uncertainty

associated with disease management analyses, it is probably not possible to 'prove' that disease management positively affects ROI by the legal standard of 'beyond a reasonable doubt.' That means ROI assessments should not be based on a single study. Rather, evidence should be refreshed constantly with new data. This will assure those who pay the health care bills that the investments they made months or years earlier were intelligent ones."

Mr. Goetzel said most of the 44 studies he reviewed focused on whether disease management programs encourage application of evidence-based clinical guidelines in treating acute and chronic disease, and whether adherence to guidelines improves patient health and functioning. Only a small subset of the studies also considered financial savings from disease management and, in particular, whether the programs can achieve a positive ROI.

Results are presented for programs attempting to improve asthma, congestive heart failure, diabetes, depression, and multiple condition disease management. Mr. Goetzel noted the researchers avoided addressing the issue of whether disease management programs are effective from a health improvement perspective.

"We assumed that following evidence-based clinical guidelines would improve the health and functioning of patients," he wrote, "though it is also acknowledged that all health care interventions may produce unintended consequences. … Our primary interest was whether disease management held the potential for saving money and producing a positive ROI."

From a purely financial perspective, he said, disease management programs directed at patients suffering from congestive heart failure may save more money that the cost. Those programs produced a positive ROI, even in the short run (one to two years). Also, programs that target multiple health and disease conditions, and which emphasize self-care and informed decision-making, also hold promise to be cost-beneficial.

"ROI is always an estimate and there are many biases that can influence it. There will never be an ROI study that cannot be improved. Thus, the analysis should include a discussion of the study's strengths and weaknesses. . ."

Thomas Wilson
Principal, Wilson Research

Mixed results came when the researchers considered programs directed at asthma, diabetes, and depression.

"The evidence for asthma programs showed that these programs can achieve a positive ROI," according to Mr. Goetzel, "but findings were not consistent, especially when examining rigorous evaluations. In the case of depression management programs, none of the studies examined found a medical cost offset for appropriate treatment of depression patients using pharmacological agents and/or psychotherapy. Quite uniformly across the various studies examined, good treatment of depression cost more money (about $500 more a year). The story may be different when considering productivity and functionality outcomes [e.g., absence, disability, on-the-job productivity, and performing activities of daily living]."

McKesson's Mr. Wadhwa says that while the evidence in favor of disease management isn't compelling as many would like, when states need to make decisions to reduce costs and improve quality, the disease management studies provide more evidence than they have for many other possible interventions.

Missing from Mr. Goetzel's work, Mr. Wadhwa says, is the need for an opportunity analysis — looking for those conditions or populations where there is a greater opportunity for savings.

"I believe that should be the first step — to be sure there is enough severity of illness that a disease management intervention can have an impact," he says.

In McKesson's disease management practice, Mr. Wadhwa says, some clients were told to look elsewhere if saving money is the goal but proceed if they want improved quality.

He says it's McKesson's experience that heart failure programs deliver short-term savings and improve patient health status quickly. It's also true with McKesson programs in Medicaid and Medicare populations, he said. McKesson also sees significant impact in asthma programs. "Asthma interventions can be very effective if you look at the total patient cost and not just asthma costs," he says.

Mr. Wadhwa says in the future, he expects disease management programs to be seen increasingly as part of the physician-patient relationship. He says there is a need to get care out of doctors' offices and disease management services can make care more effective.

He also expects to see more expertise in disease management developed for patient mental health and behavioral health services. McKesson sees a need to strengthen its offerings in that area, he says.

[Download the study from www.cms.hhs.gov/review/05summer/. Contact Dr. Wadhwa at (415) 983-8300.] ■

SCHIP reduces some, but not all, racial disparities in health care

Enrollment in an SCHIP program can improve access to health care services, continuity of care, and quality of care for all racial and ethnic groups. It also can reduce preexisting racial and ethnic disparities in access, unmet health care needs, and continuity of care. But racial and ethnic disparities in quality of care remain, despite improvements for all racial groups, according to a study by researchers at the University of Rochester (NY) medical school.

It has been shown that racial and ethnic disparities are associated with a lack of health insurance. And although the SCHIP program provides insurance to low-income children, many of whom are members of racial and ethnic minority groups, little is known about whether SCHIP affects racial and ethnic disparities among children who enroll.

Using parent telephone surveys just after SCHIP enrollment in the New York State program and then after one year, the researchers looked at usual source of care, preventive care use, unmet needs, patterns of usual source of care use, and parent-related quality of care before versus during SCHIP.

The researchers reported that before SCHIP, a greater proportion of white children had a usual source of care (95%), compared with black children (86%) and Hispanic children (81%). Nearly all children had a usual source of care during SCHIP (98% white, 95% black, and 98% Hispanic).

Before SCHIP, black children had significantly greater levels of unmet needs relative to white children (38% vs. 27%), whereas white and Hispanic children did not differ significantly. Also during SCHIP, racial and ethnic disparities in unmet need were eliminated, with unmet need at 19% for all three racial/ethnic groups.

Before SCHIP, more white children made all or most visits to their usual source of care, relative to black or Hispanic children. All improved during SCHIP with no remaining disparities.

Parent-rated visit quality improved for all groups, but pre-existing racial/ethnic disparities remained during SCHIP, with improved yet relatively lower levels of satisfaction among parents of Hispanic children. The researchers concluded that sociodemographic and health system factors did not explain disparities in either period.

The researchers said despite evidence that lack of insurance contributes to racial/ethnic disparities, evidence has been scant that provision of health insurance to vulnerable children reduces pre-existing disparities.

National-level analyses have suggested that health disparities have not been reduced in children over the last 20 years despite Medicaid expansion and other efforts to provide health insurance to children, and that racial and ethnic disparities exist even without populations that have similar insurance coverage.

"Two of our findings demonstrate important successes of SCHIP in addressing racial/ethnic disparities," the researchers wrote. "First, all racial/ethnic groups showed marked improvement after enrollment in SCHIP for all measures. Second, statistically significant preexisting disparities in measures of access, unmet need, and continuity of care were virtually eliminated during SCHIP, and these effects remained even after controlling for sociodemographic factors such as income and family factors and health system factors such as changing the usual source of care."

Despite provision of health insurance, racial and ethnic disparities remained in use of preventive care and in ratings of visit quality. Although all racial and ethnic groups experienced an increase in use of preventive care and improved quality, Hispanic children continued to have the lowest levels during SCHIP. The researchers said the findings support results from other studies that health insurance is an essential first step toward improving care but may not result in optimal care by itself. They said their work demonstrates SCHIP's success in ensuring access to a usual source of care and markedly improved continuity of care there.

Quality disparities logical

They said it is logical that disparities remain in quality and suggested that consideration of differences in language, acculturation, or perception and reporting of health care experiences between and within different racial groups can lead to additional understanding of the barriers that remain within health care settings and even within established patient-provider relationships and may suggest strategies beyond health insurance alone that are necessary to eliminate remaining disparities.

"The results of this study have implications for the pursuit of national goals to eliminate racial and ethnic disparities in health," the authors said. "First, the shift toward a usual source of care for all or most care may reduce fragmentation of services and provide increased opportunities for primary care providers to establish and maintain relationships with children and families over time, potentially contributing to improved measures of quality over longer periods of observation. Second, the relatively smaller scale

of improvement among Hispanic children raises questions about the nature of these disparities and alternative strategies to combat them. Additional work beyond the provision of health insurance should strive to understand better the causes of continued disparity and should test creative strategies that are designed to address and eliminate disparities in Hispanic children.

"Third, although disparities in access to care were nearly eliminated, disparities in quality of care remained. This study highlights the importance of ongoing initiatives to improve quality of care for all racial and ethnic groups."

Keep optimistic expectations

The researchers said policy-makers should maintain optimistic yet reasonable expectations for SCHIP. They said their finding of reduced disparities in key child health care measures after SCHIP enrollment represents an important achievement in providing health insurance to low-income families.

Future expansion of SCHIP or of other health insurance programs for children and additional research on mechanisms of disparities may both improve care and reduce disparities among vulnerable children, they said. ■

GAO: Consultants help states increase Medicaid reimbursement

In a report requested by Senate Finance Committee chairman **Chuck Grassley**, R-IA, the Government Accountability Office says 34 states as of 2004 used contingency-fee consultants to implement projects in order to maximize federal Medicaid reimbursements.

GAO (formerly the General Accounting Office) analysts looked at five categories of Medicaid claims — targeted case management services, rehabilitation services, supplemental payment arrangements, school-based services, and administrative costs. The agency reported that in Georgia and Massachusetts, the two states that were reviewed, contingency-fee consultants developed projects in all five categories. From those and other projects, for state fiscal years 2000 through 2004, Georgia obtained an estimated $1.5 billion in additional federal reimbursements, while Massachusetts took in an estimated $570 million. The two states paid contingency fees of more than $90 million.

GAO recommended that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. CMS said its initiatives substantially respond to the recommendations and the states said their projects comply with the law. GAO said additional actions are still needed.

Over the past few years, the GAO reported, states' claims in some of the five categories examined have grown substantially in dollar amounts. During fiscal years 1999 through 2003 combined federal and state spending for targeted case management increased by 76%, from $1.7 billion to $3 billion, across all states.

"We identified claims from projects developed by contingency-fee consultants that appeared to be inconsistent with current CMS policy, claims that were inconsistent with federal law, and claims from projects that undermined the fiscal integrity of the Medicaid program," the GAO told Grassley.

Concerns identified in two of the five categories of claims reviewed were:

1. Targeted Case Management. Consultants in Georgia and Massachusetts helped the states maximize federal reimbursements by claiming costs for targeted case management services that, under state plan amendments approved by CMS before 2002, appear to be inconsistent with CMS' current policy, which does not allow federal Medicaid reimbursement for targeted case management services that are an integral component of other state programs providing the services. For example, GAO said, Georgia and Massachusetts claimed and received federal Medicaid reimbursement for targeted case management services for youths in the states' juvenile justice systems.

2. Rehabilitation Services. Georgia's consultant helped the state increase federal reimbursements for rehabilitation services provided through state agencies by $58 million during state fiscal years 2001 through 2003. The consultant suggested that two state agencies that pay private facilities for providing room and board, rehabilitation, and other services to children in state custody base claims for Medicaid reimbursement on the private facilities' estimated costs, instead of what the agencies actually paid the facilities. The agencies increased the amount claimed for reimbursement without increasing payments to the facilities. In some cases, GAO said, the amount state agencies claimed for rehabilitation services alone exceeded what they paid for all the services the facilities provided to children.

The report identified two factors shared by projects where claims are at high risk of creating a problem: 1) projects are in Medicaid claims categories where federal policy has been

inconsistently applied, is evolving, or is not specific; and 2) Medicaid payments are made in many cases to state and local government agencies as Medicaid providers, a mechanism that can facilitate an inappropriate shift of state costs to the federal government.

According to GAO, the two states reviewed and the federal government provided limited oversight to ensure the appropriateness of the projects and associated claims developed with assistance from contingency-fee consultants.

"Georgia's and Massachusetts' oversight efforts were limited and insufficient to prevent problematic claims associated with contingency fee projects," the report said. "CMS relies primarily on the states and its own financial oversight activities to ensure the appropriateness of consultant projects and claims. Although CMS has periodically identified concerns with contingency-fee projects to maximize federal reimbursements, the agency has not routinely collected information to identify such projects and claims, and it was unaware of many of the specific projects that we reviewed. Our findings illustrate the urgent need to address broader oversight and financial management issues not limited to situations involving contingency-fee consultants."

GAO recommendations

To help remedy the situation, GAO recommended that the CMS administrator: 1) routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents such as state plan amendment proposals, cost allocation proposals, and expenditure reports; and 2) enhance CMS review of state Medicaid documents in which states have used a contingency-fee consultant and take appropriate action to prevent or recover federal reimbursements associated with unallowable claims.

To strengthen CMS' overall financial management of state Medicaid activities, GAO recommended five actions for the CMS administrator: 1) require that states identify in Medicaid documents arrangements or claims for payments that involve payments to units of state or local government, such as state and local government-owned or operated facilities; 2) enhance CMS' review of states' Medicaid documents, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims; 3) establish or clarify and then communicate CMS policies on targeted case management, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs, and then ensure that policies are applied consistently across all states; 4) ensure that states submit cost-allocation plans as required and establish a procedure for their prompt review; and 5) follow up with states' associated claims covered in the report and recover federal reimbursements of unallowable claims as appropriate in Georgia and Massachusetts.

CMS said the GAO report did not accurately reflect its many activities already taken to address the issues raised and that many of the recommendations already are being followed. In its comment on the CMS response, GAO acknowledged the agency has taken important actions in recent years to improve Medicaid financial management, but also noted it has raised concerns about certain inappropriate financing methods in high-risk areas for many years, that some prior recommendations remain open, and that problems remain.

"In addition to the important steps CMS has taken in recent years to improve its policies and oversight, we believe that more can and should be done to better ensure the program is operating as Congress intended, that is, as a shared federal-state partnership providing health care resources for covered services for eligible beneficiaries," GAO said.

Officials from Georgia and Massachusetts told GAO of the importance of contingency-fee contracts and states' use of consultants in helping secure resources they otherwise would not have. Massachusetts said that seeking federal resources for people in need when those resources are lawfully available is a fiscally responsible thing for states to do. Georgia said Medicaid's complexity compels states to turn to expert consultants for assistance and said the report inaccurately suggests that states' use of contingency-fee consultants is somehow illegitimate.

"We acknowledge that use of contingency fee contracts is allowed under law and that states can employ consultants for a number of valid Medicaid purposes, and our report has made these points," GAO said. "Our key findings, however, focus on the need to ensure that financing methods and associated claims that stem from contingency-fee projects are consistent with federal law, policy, and the fiscal integrity and federal-state partnership of the Medicaid program. Our work identified concerns with claims from contingency-fee projects that were problematic in these respects."

On receiving the report, Mr. Grassley said, "It's alarming to find that a majority of states use contingency-fee consultants to increase the federal dollars they claim from Medicaid and that these increases are often achieved through schemes

of questionable legality. Medicaid dollars should not be lining the pockets of consultants who plot new ways to exploit the system."

Meanwhile, concerns such as these and other criticisms of the Medicaid program and its administration haven't translated into negative public opinion about the program. A Kaiser Family Foundation study found that while two-thirds of the public think their state has major budget problems, a substantial majority is reluctant to cut Medicaid to balance state budgets, and a majority think the federal government should maintain (44%) or even increase (36%) federal spending on Medicaid. Only 12% of respondents favored some sort of Medicaid cut.

Nearly three-quarters of the adults surveyed said Medicaid is a "very important government program," ranking it close to Social Security (88%) and Medicare (83%) in the public's mind, equal to federal aid to schools (74%), and above defense and military spending (57%).

A majority of Americans (56%) report having some interaction with Medicaid, either having been enrolled themselves at some point (16%) or knowing a friend or family member who has received health coverage or long-term care assistance through the program (40%). Also, if they needed health care and were eligible, 78% of respondents said they would be willing to enroll in Medicare.

"We expected Medicaid to be relatively unpopular with the public, much like welfare was," said Kaiser vice president and director of public opinion and media research **Mollyann Brodie**. "But we found that Medicaid ranks closer to popular programs like Medicare and Social Security in the public's mind. The fact that so many Americans have had some kind of contact with Medicaid themselves or through family and friends is one factor that could help explain this result."

[Download the GAO report from www.gao.gov/cgi-bin/getrpt?GAO-05-748. Contact Ms. Brodie at (202) 347-5270.] ■

Medicaid reform program in Florida allows a choice of health care plans

HHS has approved an innovative Medicaid reform program allowing Floridians to choose health care plans that best suit their needs, bringing competition and consumer choice into Medicaid for the first time.

"Introducing competition and consumer choice will improve quality of care and empower Florida's 2.2 million Medicaid beneficiaries," said HHS Secretary **Mike Leavitt**. "I commend Gov. Bush for his leadership in transforming the state's program."

Enrollees will play a more active role in deciding how they will receive health care by selecting from a group of state-approved managed care plans that will compete for the business. They will have up to 30 days to choose a health plan. If none is chosen, the beneficiary will be automatically enrolled in a state-selected plan.

Unsustainable rate

Florida officials had determined their Medicaid growth rate of 13% a year for the past six years was unsustainable. In 2005, for example, Medicaid spending is expected to take 25% of the state's budget, more than $15 billion a year. State officials said that under the §1115 waiver demonstration, the state can maintain a reasonable rate of growth while providing enrollees access to improved quality health care services.

Beneficiaries will be able to choose a managed care plan with a benefits package that best suits their needs. The demonstration will allow plans to customize benefits packages, although each plan must cover all mandatory services detailed in federal law. Plans may enhance their benefits packages in an effort to attract more enrollees.

In addition to a choice of plans, beneficiaries also have for the first time an opportunity to opt out of Medicaid altogether and receive subsidies for their share of the cost to purchase employer-sponsored insurance.

Beneficiaries who choose employer-sponsored coverage will be entitled only to the benefits covered by that plan as well as to any cost-sharing requirements, even if they exceed normal Medicaid limits. Beneficiaries considering switching to an available employer plan will be offered individualized counseling about its potential benefits and risks. Opting out is voluntary, and beneficiaries may choose to rejoin Medicaid within 90 days of opting out.

New incentives

Another new feature of the Florida demonstration is establishment of the enhanced benefit account (EBA) program, with direct incentives to Florida demonstration enrollees who participate in state-defined activities that promote healthy behaviors such as weight management, smoking cessation, and diabetes management.

Beneficiaries will be allowed to accumulate funds in their EBA and use them for noncovered health-related needs such as over-the-counter medications. Those who

leave Medicaid can use any funds remaining in their EBA account for health-related uses for up to three years as long as their incomes remain at or below 200% of the federal poverty level.

Paying providers

The demonstration will establish a $1 billion fund annually to help the state pay safety net providers caring for the uninsured.

The state begins this demonstration in Broward and Duval counties in July 2006, with statewide implementation following. The demonstration runs through June 30, 2011. ■

ED REACT could reduce number of ED patients leaving untreated

ED REACT (Emergency Department Rapid Entry and Accelerated Care at Triage), a program of the American College of Emergency Physicians, could significantly decrease the number of patients who leave hospital emergency departments without being treated, despite an increasing volume of patients seeking care, according to a study published on-line by *Annals of Emergency Medicine*.

The Government Accountability Office says that as many as 7% of emergency departments nationally have "leave without being seen" rates higher than 5%, with some EDs reporting rates as high as 15%.

Holes in the net

"Patients who leave emergency departments before being seen by a physician represent a failure in the health care 'safety net' and hinders the nation's ability to meet its Healthy People 2010 objective to reduce the number of people who have difficulty getting emergency care," says study lead author **Theodore Chan**, with the San Diego Medical Center Department of Emergency Medicine. "Our study indicates that emergency departments can take steps to reduce the number of people who leave before receiving care."

ED REACT streamlines the registration process, improves triage efficiency, and begins tests and interventions on patients before they are placed in emergency department beds. As a result of the program, Chan wrote, an urban emergency department was able to reduce the frequency of patients who left without being seen by almost 50%.

Less waiting

Researchers attributed the decrease to the program's ability to decrease patient wait times for care by 24 minutes and patients' average length of stay in the emergency department by 31 minutes.

"While there have been many efforts to reduce the number of patients who leave an emergency department without being seen by a physician, our program differs significantly because we focused on patients with acute or urgent medical conditions, while others have focused primarily on patients with nonurgent conditions," according to Chan. "We focused on those with urgent medical conditions because research has shown these patients are most likely to leave and most likely to return to the emergency department later and in worse condition." ■

This issue of *State Health Watch* brings you news from these states:

State Health Watch
The Newsletter on State Health Care Reform

2005 Index

State Index