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The following is the next in our series of monthly member spotlights. NAMD is featuring the launch of a new initiative or a programmatic development of interest from one of our members.

Utah Medicaid offers lessons for ER diversion programs
Limiting inappropriate use of the emergency room has become a hot topic in the cost-containment arena. According to the most recent year of data (2008), 9.5 percent of the ER visits by Medicaid beneficiaries are coded as “non-urgent”, compared to 6.3 percent of those privately insured. The growth in Medicaid enrollment during the recession has made non-emergent use of the ER a significant problem, with major costs associated.

States have sought a variety of ways to help consumers, providers, and hospitals be more strategic. Successful interventions are beneficial to all of these players as well as to the bottom line. ER diversion can alleviate overcrowding in ERs and nursing shortage concerns. Patients who receive their primary care and chronic care management in a health home or from a PCP will have more coordinated care, and likely better health outcomes in the long run. Furthermore, it is often true that primary care providers have limited access to the health information on patients seen in the ER, and may not be able to fully manage their patients health care needs and conditions.

In 2008, 20 states received funding from CMS and HRSA to help address this issue. States conducted one or more pilots designed to target the three parties to the decision about where services are delivered—hospitals, providers and enrollees themselves. The types of interventions included:

- Identification and outreach to high ER users. Using Medicaid and hospital data, those individuals using ERs multiple times for non-urgent care received targeted outreach to help them find sources regular source of care.
- Care coordinators were placed in ERs, again to help non-emergent care needs to be addressed, and to improve follow-up and reduce return visits.
- Consumer education was provided to all enrollees about the impact of non-emergent ER use, and alternative options.
- Provider groups and community health centers were encouraged to expand their hours, and educate their patients on the importance of regular primary care and chronic condition care.
Utah was one of those states engaging in an ER diversion program. A major component of their program was a consumer education effort called “Is it Safe to Wait?” This campaign included a website (http://health.utah.gov/safetowait/) which helped consumers think about when to go to the ER. It provided information on primary care practitioners and urgent care centers in the consumer’s area that could were an alternative to visiting the ER.

In addition to the website, Utah Medicaid also conducted a study of consumer behavior under a case-control model. Utah identified excessive, inappropriate ER users and assigned some to a study group (with strictly defined parameters and appeals opportunities). In this program, recipients who used the ER three or more times in a year for non-emergent conditions were enrolled in a program that encouraged them to limit their utilization to their primary provider and an assigned urgent care center. In a case-control analysis of this program, 11% of case enrollees used the ER inappropriately, compared to 24% of the control group. This difference resulted in a 55% decrease in non-emergent use in the restriction program enrollees, with related cost savings for these individuals.

Consumer education and the availability of regular sources of care are important aspects of hospital emergency room diversion, but a number of states are seeking additional tools to manage what is often an unnecessary cost. Several states have or intend to explore implementation of cost-sharing arrangements that discourage inappropriate use of the ER. Cost-sharing models being considered would be linked to efforts at improving enrollee access and utilization of disease management services and primary care, much like those initiatives described above.

Co-pays for non-emergent ER visits have met with significant resistance. However, targeted increases in cost-sharing to affect consumer will continue to be a route states will consider, particularly in as part of efforts to improve care coordination and health outcomes. Regardless of the success of cost-sharing efforts, states will likely continue to view ER diversion as a key strategy and a hoped for outcome of other efforts to improve primary care, including health homes and Health Center expansion.

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- **NAMD Fall Conference agenda details released.** On November 7-9, the NAMD Fall Conference will be convened in Washington, DC. All state Medicaid Directors and appropriate agency staff are invited to attend NAMD’s all-state meeting, November 7th. Individuals and organizations interested in the latest operational and policy developments in the Medicaid program are invited to attend the public meeting, which kicks off with a reception the evening of November 7th. A breakfast with current and former Medicaid directors is scheduled for November 8th. In addition to a wealth of state presentations, several officials from the U.S. Department of Health and Human Services will highlight important initiatives underway and congressional staff will discuss the outlook for legislative action. The draft agenda is posted online at: https://custom.cvent.com/7E4FC58CE40643FF9BB17C52411311BB/files/8f951eae21f24e3095578ea025b7ee7.pdf

- **NAMD posts paper on Medicaid FMAP changes.** The fiscal year (FY) 2013 FMAPs will again show substantially more reductions than increases, with 24 states experiencing a decline of 0.50 percentage points or more and only 12 receiving that level of increase. This partly reflects personal income shifts among the states, and partly the impact of a first-time use of the 2010 decennial census data. A new paper by one of Medicaid's finance experts examines the data and trends. The
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- **Reminder about NAMD's Fall Conference.** Registration is open for the 2011 NAMD Fall Conference. The conference is scheduled for November 7-9, 2011, at the Marriott Crystal Gateway in Arlington, Arlington, VA 22202. Visit our website for more information: www.namd-us.org

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- **CMS updates Part D clawback, nominal cost-sharing amounts.** On September 30, CMS released an informational bulletin concerning states’ Medicare Part D clawback amounts for October through December 2011 and January through September 2012. Although the phased-down contribution percentage is reduced from 81-2/3 percent of projected state per capita expenditures to 80 percent, the net change in the state clawback amounts for CY2012 is 1.98 percent. The informational bulletin also discusses updates to nominal cost-sharing amounts. The update is based on the change in the medical care component of the consumer price index for all urban consumers (CPI-U). The net change in CPI-U from September 2009 to September 2010 is 3.4 percent.

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- **Supercommittee gets recommendations on fraud and abuse legislation.** Last week Sens. Tom Carper (D-DE) and Tom Coburn (R-OK), sent a letter urging the supercommittee to adopt their bipartisan fraud and abuse legislation, The Medicare/Medicaid Fighting Fraud and Abuse To Save Taxpayer Dollars -- or FAST Act (S. 1251), as part of its recommendations to Congress. Introduction of a House version of the FAST Act is expected shortly. In Medicaid, among other things the FAST Act would increase support for the One Program Integrity (PI) Integrator program, prohibit payment of Medicaid claims unless the claim for payment for an item or service contains a beneficiary identification and a National Provider Identifier, require that states ensure that Medicaid managed care plans conduct certain database checks, expand the entities that could access Medicare data, and expand access to the National Practitioner Databank. Separately, several advocacy and provider organizations sent a joint letter to the supercommittee urging them to focus on program integrity, not beneficiary or provider cuts.

While being responsive to members’ requests to advance program integrity legislation, during a hearing last month Congressional Budget Office (CBO) Director Douglas Elmendorf told super committee members there is no evidence that reducing fraud and improper payments would constitute “a substantial share” of savings needed to deficit reduction. One hurdle for the supercommittee is a rule that essentially prevents the CBO from assigning federal savings to certain program integrity legislation. However, reports last week indicated that there has been discussion that the supercommittee could call for repealing or changing this rule. According to some congressional staffers, even if the supercommittee does not include the Fast Act in its budget proposal, there remains strong support among Members of Congress.
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- **SC Director, NAMD warn against cost shifts.** Reuters’ David Morgan spoke with NAMD’s Matt Salo and South Carolina Medicaid Director Tony Keck for his article, “Analysis: States lobby against Medicaid cuts in Congress.” Responding to questions about federal Medicaid proposals that would result in cost shifts to states, Mr. Salo stated, “That's a head-in-the-sand approach. But there are ways to look at Medicaid changes -- some of which would be helpful and some of which would make the problem worst.” Mr. Keck told Reuters, “Every state is in agreement that if all the federal government does to reduce its deficit is push costs and mandates onto the states ... it's really a nonstarter.” See: [http://www.reuters.com/article/2011/09/29/us-usa-debt-states-medicaid-idUSTRE78S0PK20110929](http://www.reuters.com/article/2011/09/29/us-usa-debt-states-medicaid-idUSTRE78S0PK20110929)

- **Seattle PI focuses on Washington’s ER initiatives.** The Seattle PI recently spoke with Doug Porter, director of the Washington state Health Care Authority, about the state’s initiative to limit non-emergency Medicaid visits to the ER. Mr. Porter was quoted as saying, “This is a realistic strategy to change clients' behavior and improve patient care as well as assure taxpayers that we are addressing the state's continuing financial crisis.” See: [http://www.seattlepi.com/news/article/Wash-to-limit-Medicaid-emergency-room-visits-2189394.php#ixzz1ZfRoFNLc](http://www.seattlepi.com/news/article/Wash-to-limit-Medicaid-emergency-room-visits-2189394.php#ixzz1ZfRoFNLc)

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- **New Medicaid pharmacy reports released.** The Kaiser Family Foundation’s Commission on Medicaid and the Uninsured recently released three papers that examine issues related to Medicaid and prescription drugs. The documents include “Medicaid Payment for Outpatient Prescription Drugs.” Two others, “Managing Medicaid Pharmacy Benefits: Current Issues and Options,” and “The Role of Clinical and Cost Information in Medicaid Pharmacy Benefit Decisions: Experience in Seven States” were informed by interviews with Medicaid pharmacy administrators among others. Kaiser’s reports are posted at: [www.kff.org](http://www.kff.org)

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- **NAMD Fall Conference,** November 7 (state-only day) and November 8-9 (open meeting): [http://www.cvent.com/d/9dqhpx](http://www.cvent.com/d/9dqhpx)
  - November 7th: Welcome Reception
  - November 8th: Medicaid Director Breakfast with Alumni Directors