



OPTIONS TO ADDRESS HIGH COST MEDICAID CLIENTS

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
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ISSUE BRIEF

SUMMARY

This brief provides information on what is being done in Utah as well as in other states to address high cost Medicaid clients. Washington State Institute for Public Policy recommended ten disease groups in Medicaid where interventions may reduce costs and improve health outcomes. The diseases chosen by half of more of all states as a target for intervention were the following: diabetes (84%), asthma (78%), congestive heart failure (56%), and chronic obstructive pulmonary disease (50%). This brief is for informational purposes only and requires no Legislative action.

DISCUSSION AND ANALYSIS

Who are High Cost Clients?

In Utah in FY 2010, 1.0% or 3,379 clients accounted for 25% of all Medicaid expenditures. These clients may be high cost for any number of reasons. Some of the reasons for high costs clients include: catastrophic accidents, premature deliveries, complicated chronic conditions, and organ transplants.

What is Utah Medicaid Doing to Address High Cost Clients?

In Utah, the Medicaid Program uses the following optional strategies to address high cost clients:

1. **At risk contracting for medical services** – about 40% of all Medicaid clients receive services through a fully capitated contract with Molina Health Care. Molina Health Care bears the full financial risk of managing client costs within the per member per month payment from Medicaid. In an October 7, 2011 email Molina indicated that it does the following, in order of importance to manage costs:
 - a. **Prior authorization** – for high cost medical services and over-utilized services
 - b. **Concurrent review of facility admissions** – for verifying appropriateness of admission and length of stay at hospitals and skilled nursing facilities.
 - c. **Case management following facility discharge** – ensure client receives necessary services
 - d. **High-risk pregnancy case management**
 - e. **Contracting for volume discounts** – direct clients to certain providers for larger discounts
 - f. **Staff reminding clients to get regular health screenings**
 - g. **Emergency room diversion program** – phone calls, letters, and urgent care information
 - h. **Disease management** – for clients with asthma and diabetes
2. **Emergency room diversion program** - As of August 2009, the Department of Health intervenes with all inappropriate Medicaid users of the emergency department. The Department received \$400,000 annually total fund to intervene and previously estimated saving \$2,019,000 total fund. For more information on the interventions used please visit www.health.utah.gov/safetowait.
3. **Contract with a drug regimen review center** - review some Medicaid cases monthly for potential adverse drug reactions and/or duplicate prescriptions.

4. **Abuse potential/drug over utilization** – clients considered for the Restriction Program (can only use one pharmacy) when they take several drugs with high potential for addiction and/or are receiving similar prescriptions from two or more providers for potentially addictive drugs.

For Which Clients Might Intervention Help?

Work done by the Washington State Institute for Public Policy

(<http://www.wsipp.wa.gov/rptfiles/HighCostMedicaid.pdf>) suggested the following “disease groups most likely to benefit from case management:”

- Asthma
- Coagulation defects (conditions that stop blood clotting)
- Diabetes
- Heart Failure
- Intervertebral Disc Disorders (degeneration of discs in the spine)
- Malignancy (tumor or cancer)
- Obesity
- Poisoning by Medical Substances
- Renal disease (kidney problems)
- Transplants

Their recommendations came after studying Washington State’s fee-for-service Medicaid claims data. The study used four criteria in selecting disease groups: (1) “concentration of high-cost patients,” (2) “substantial share of Medicaid expenses,” (3) “research suggesting the feasibility of improving patient outcomes while reducing costs,” and (4) “little or no existing case management.”

What are Some Potential Interventions?

The diseases chosen by half of more of the states as a target for intervention were the following: diabetes (84%), asthma (78%), congestive heart failure (56%), and chronic obstructive pulmonary disease (50%). The National Conference of State Legislatures (NCSL) estimates that 40 or 80% of the 50 U.S. states had some kind of disease management program for Medicaid clients as of July 2007

(<http://www.ncsl.org/default.aspx?tabid=14421>). Of those 40 states with programs, 32 states targeted a specific disease or diseases for intervention, which is shown in the table below. The percentages next to the disease category in column 2 represent how often a state chose to target that disease.

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Disease Category		AL	AR	CA	CO	CT	DE	FL	GA	ID	IL	IN	IA	LA	MD	ME	MN	MS	MO	NH	NJ	NY	NC	ND	OR	RI	TN	TX	UT	VT	VA	WV	WI		
Diabetes	84%	1		1	1	1	1	1	1	1	1	1	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		
Asthma	78%	1		1	1		1	1	1		1	1	1		1	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		
Congestive Heart Failure	56%				1		1	1	1			1	1					1	1	1	1	1	1	1	1	1	1			1		1	1		
Chronic Obstructive Pulmonary Disease	50%				1		1	1	1		1							1	1	1		1	1	1	1	1	1	1	1			1			
Coronary Artery Disease	31%						1		1		1									1	1			1	1	1	1			1		1	1		
Depression	19%				1											1					1				1	1			1						
Hypertension	19%						1	1				1						1									1	1							
Kidney Disease/Failure ¹	19%						1	1												1	1							1				1	1		
Maternity Care ²	19%		1	1			1								1											1							1	1	
Mental Illness ³	16%									1	1										1					1	1								
Cardio Related Conditions ⁴	13%					1									1	1			1																
Sickle Cell	13%							1										1				1				1									
Heart Disease ⁵	9%			1							1																		1						
Hemophilia	6%							1	1																										
HIV/AIDS	6%							1														1													
Lower Back Pain	6%															1														1					
Obesity (Childhood or General)	6%					1																					1								
Anticoagulation/Antiplatelet Drugs	3%																													1					
Arthritis	3%																															1			
Cancer	3%													1																					
Gastroesophageal Reflux Disease	3%																		1																
Hyperlipidemia	3%																																1		
Pain Management	3%																													1					
Parkinson's	3%			1																															
Stroke	3%			1																															
Transplant	3%						1																												

¹Kidney Disease/Failure includes the following NCSL categories - Chronic Kidney Failure, Chronic Kidney Failure Disease, Renal disease, End Stage Renal Disease, and Renal Failure

²Maternity Care includes the following NCSL categories - Maternity Care, High-risk Pregnancy, and New Mothers

³Mental Illness includes the following NCSL categories - mental Illness, Antipsychotic Therapy, Bipolar Disorder, and Schizophrenia

⁴Cardio Related Conditions includes the following NCSL categories - Cardio Related Conditions and Cardiac Services

⁵Heart Disease includes the following NCSL categories - Heart Disease and Ischemic Heart Disease

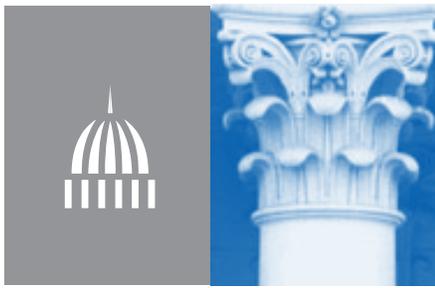
Utah does some intervention for diabetes and asthma, but does not target congestive heart failure nor chronic obstructive pulmonary disease. Additionally, Utah targets the following disease/treatments for intervention: hypertension, mental illness, anticoagulation/antiplatelet drugs, and pain management.

The National Conference of State Legislatures reported the model or models used for the disease management intervention for 35 of the 40 states with programs. For the 35 reporting states, 91% used a patient care intervention while 37% used pharmaceutical information as a basis for the intervention. Utah uses pharmaceutical information for its disease management efforts.

Sources Used

- “High-Cost Medicaid Clients: Targeting Diseases for Case Management,” Steve Lerch, Ph.D. and Jim Mayfield, December 2000, Washington State Institute for Public Policy, available at <http://www.wsipp.wa.gov/rptfiles/HighCostMedicaid.pdf>
- Information in table organized from the following data: “State Medicaid Disease Management Program Descriptions,” National Conference of State Legislatures, information accessed October 6, 2011 from <http://www.ncsl.org/default.aspx?tabid=14421>

APPENDIX A – “DIVERTING COSTLY EMERGENCY ROOM VISITS TO HEALTH CENTERS” BY THE NATIONAL CONFERENCE OF STATE *LEGISLATURES*



Diverting Costly Emergency Room Visits to Health Centers

By Hollie Hendrikson and Melissa Hansen

Non-emergency visits to the ER are costly.

Hospital emergency rooms (ERs) are a vital part of America's health care system. They respond to acute illnesses and injuries 24 hours a day, seven days a week. Federal law requires almost all emergency rooms to examine and, if necessary, stabilize everyone who seeks care, regardless of their ability to pay, perceived need or immigration status. Inadequate access to primary or preventive care, uncontrolled chronic conditions such as asthma or diabetes, and lack of insurance are some reasons patients seek non-emergency care at ERs. The problem with a non-emergency visit to an emergency room is that it can cost up to seven times more than a visit to a health center.

People who have no insurance visit ERs more often.

A 2008 study by the Centers for Disease Control and Prevention found that those who had no insurance sought medical care in emergency departments at more than twice the rate of those with private insurance. According to the Institute of Medicine, Medicaid patients have higher rates of emergency department use compared to patients with other sources of payment. Therefore, states often end up paying for emergency room visits through Medicaid or other state coverage programs.

In many states, health centers are trying to curb unnecessary emergency department use, and in a few states, they are getting support from the legislature. A May 2011 Government Accountability Office report highlights health center strategies (new emergency department diversion programs, better coordination of care, and more accessible services) that encourage people with non-emergency health needs to seek care at more appropriate facilities.

Health centers provide less expensive care for the uninsured.

State Action Thirty-three states and the District of Columbia allocated \$354 million in direct state funding to health centers in 2011 to cover the cost of providing care for uninsured or indigent patients, additional services or hours, and capital improvements. Some of this funding has also supported health centers' role in reducing unnecessary emergency department use.

Emergency Department Diversion. To reduce the use of emergency departments by the uninsured or those with no primary care, some hospitals partner with health centers to guide patients away from the ER and into a health clinic when appropriate. Patients who visit the ER often are targeted for educational services.

The Baltimore Medical System, for example, uses community health workers to discuss services offered at nearby health centers and make follow-up appointments or referrals for interested patients. Communication and cooperation between health centers and hospitals are essential to the success of these programs. Legislators can help foster such collaboration by attaching conditions to health center or hospital funding.

Care Coordination. To reduce emergency department visits that result from chronic diseases, health centers are using the "medical home model" of care. This model uses a team of health pro-

professionals to provide continuous, comprehensive care for patients, coordinating all levels of their care, including mental health and chronic care services. Coordination of services also can connect patients with community services or refer them to specialty care. A 2007 study by the National Association of Community Health Centers found that medical expenses of patients who had medical homes at health centers were 44 percent lower than comparable patients seen elsewhere, resulting in savings to the nation's health care system of between \$9.9 billion and \$17.6 billion a year.

Minnesota lawmakers in 2008 decided to allow additional coordination payments for certified health care homes. These payments act as an incentive to better manage patients with chronic or complex health needs and keep them out of emergency rooms.

Accessible Services. A complex set of factors affects a person's ability to receive health care, extending beyond his or her insurance or income status. Health centers reduce many obstacles to health care and meet a diverse range of patient needs. Many centers offer extended office hours or make urgent care services more available to all patients. Some offer translation services. To increase community awareness of health care services, the Access Community Health Network in Illinois participates in local health fairs, reaches out to social service agencies, and co-brands informational materials with a local hospital.

The Michigan Legislature supported capital development projects to help health centers locate in convenient areas more preferable than emergency departments. In 2008, the state extended capital development projects funded by the Michigan State Hospital Finance Authority to include public hospitals and health care institutions. These projects contributed to the acquisition, construction, improvement or alteration of health center facilities and payment of project costs.

Federal Action Beginning in 2011 the Affordable Care Act appropriates \$11 billion to health centers over five years; \$9.5 billion of this funding will allow health centers to expand their operational capacity to enhance medical, oral and behavioral health services. Of this funding, \$1.5 billion is for capital expenditures. The intent was to nearly double the amount of patients at health centers, and it is estimated that nearly 20 million new patients will visit health centers by 2019. However, a subsequent cut of \$604 million in the federal budget in 2011 means that fewer service expansions and new health centers than anticipated will be funded with Affordable Care Act money.

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