*Members*

*Sen. Patricia Miller, Chairperson*
*Sen. Ryan Mishler*
*Sen. Brandt Hershman*
*Sen. Jean Breaux*
*Sen. Vi Simpson*
*Sen. Earline Rogers*
*Rep. Timothy Brown*
*Rep. Suzanne Crouch*
*Rep. Don Lehe*
*Rep. William Crawford*
*Rep. Charlie Brown*
*Rep. Peggy Welch*

# SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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*Authority: IC 2-5-26*

## MEETING MINUTES[1]

| | |
|---|---|
| **Meeting Date:** | **September 14, 2011** |
| **Meeting Time:** | **2:00 P.M.** |
| **Meeting Place:** | **State House, 200 W. Washington St., Senate Chamber** |
| **Meeting City:** | **Indianapolis, Indiana** |
| **Meeting Number:** | **2** |

**Members Present:** **Sen. Patricia Miller, Chairperson; Sen. Brandt Hershman; Sen. Jean Breaux; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Don Lehe; Rep. William Crawford; Rep. Charlie Brown; Rep. Peggy Welch.**

**Members Absent:** **Sen. Ryan Mishler; Sen. Vi Simpson; Sen. Earline Rogers.**

The second meeting of the Select Joint Commission on Medicaid Oversight was called to order at 2:18 P.M. on September 14, 2011, by Sen. Patricia Miller, Chairperson. Sen. Miller announced that the Commission will not meet on September 28, 2011, as previously planned, but would meet one more time in October, with the date to be decided.

**Program Integrity/ Medicaid Fraud Prevention** Kristina Moorhead, Deputy Director, Office of Medicaid Policy and Planning (OMPP)

Ms. Moorhead reviewed the state agencies and divisions of FSSA that are involved in prevention and detection of Medicaid provider and member fraud. (See Exhibit A for Ms. Moorhead's slide presentation.) She also discussed statistics for recoveries and cost avoidance activities for FY 2011 and prosecutions and restitutions information. She explained the expanded program integrity activities being implemented by OMPP that are targeted to providers and to Medicaid members. She reviewed procedures that are in place to prevent or detect provider fraud and described the Right Choices Program (RCP) that identifies Medicaid members that use an inordinate level of services.

[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

Commission questions and discussion followed regarding the Right Choices Program, how ongoing eligibility is monitored, the process of removing an ineligible individual from the Medicaid roles, and OMPP's role in identifying cases of fraud. Commission members requested additional information about the number and percentage of members on the RCP and how long they are included on the restricted program. Ms. Moorhead explained that the RCP program is designed to assist members to utilize the resources better - they are not restricted from receiving necessary services.

Pat Casanova, Director of OMPP, explained that the Recovery Audit Contractor (RAC) is a federal Medicaid program requirement that was enacted in the federal Patient Protection And Affordable Care Act (PPACA). In response to questions regarding the low number of fraud cases prosecuted she explained that OMPP identifies wrongdoers but does not have authority to prosecute them. OMPP evidence of fraud may not meet the necessary level of evidence for a successful prosecution, or a prosecutor may have other reasons for not going forward with a case of Medicaid fraud. Commission members expressed concern regarding the potential number of people receiving Medicaid services that are not eligible to be on the program. In response to a question regarding whether OMPP could discontinue Medicaid to individuals that are found to be ineligible, she said "no" and then explained that the Division of Family Resources (DFR) determines eligibility and that DFR could terminate eligibility.

**Cost Containment Initiatives** Pat Casanova, Director, OMPP

Ms. Casanova reviewed the ARRA and PPACA provisions that prohibit reductions in Medicaid eligibility and benefits. (See Exhibit B for Ms. Casanova's slide presentation.) The prohibitions mean that limiting provider reimbursement levels and limiting services to recipients are the only places the state can look to provide cost savings within the Medicaid program. She reviewed the savings target that was built into the Medicaid appropriation and referred to the February 3, 2011, letter from Kathleen Sebelius, Secretary of the U.S. Health and Human Services, containing recommendations for potential allowable cost reductions within state Medicaid budgets. (See Exhibit C.)

In response to a question about the amount of Medicaid appropriations that reverted at the end of FY 2011, Ms. Casanova stated that Medicaid had a shortfall and did not revert any funding. Later, she clarified that the Medicaid Administration appropriation reverted $148 M, while Medicaid Current Obligations, the appropriation that covers the payment for services, had a shortfall in funding.

In response to questions regarding how the provider community felt about the cuts in reimbursement, Ms. Casanova responded that most providers understand why the cuts in reimbursement must be made. She added that OMPP has received no written complaints from hospitals or nursing facilities, 74 complaints on the reduction of the dispensing fee, and no complaints from consumers. She explained that this information is anecdotal; there has been no formal survey.

**Healthy Indiana Plan (HIP) Waiting List Update** Pat Casanova, Director, OMPP

Ms. Casanova reviewed the current HIP enrollment and stated that the program has been opened for enrollment of childless adults. She also explained the process for enrolling up to 8,000 childless adults. (See Exhibit B, Pages 12 & 13 for Ms.Casanova's slide presentation.)

Commission questions followed regarding the availability of enrollment statistics by county and whether the waiting list was available by county of residence. Ms. Casanova said that enrollment by county could be provided for the HIP participants, but was unsure if the data was available by county for the persons included on the waiting list. In response to a question

regarding what the highest number of HIP participants had been, she commented that last year the enrollment was about 45,000. She added that she would have to check to see if that level of enrollment had been exceeded. Sen. Miller requested the information be supplied to staff for distribution to the Commission. There were additional Commission questions for Ms. Casanova regarding the future of the HIP program, especially with regard to the Power Account under federal healthcare reform. Ms. Casanova responded that OMPP may still apply for a State Medicaid Plan Amendment or request a continuation of the waiver. Additional questions were asked about the family planning State Plan Amendment and constituent-specific issues.

(See Exhibit D for the FSSA response to various questions asked at the Commission meeting of September 14, 2011.)

**Other Testimony** Larry Humbert, Executive Director, Indiana Perinatal Network

Mr. Humbert explained to the Commission that the Perinatal Network was surprised that targeted case management services had been discontinued as a savings measure since these services can result in significant savings when provided to at-risk pregnant women. He commented that there was two weeks' notice given that the funding was being eliminated.

Paul Chase, IN AARP, commented that OMPP had eliminated targeted case management services. In response to questions regarding what is involved in targeted case management services, Mr. Humbert explained that the program involves one face-to-face meeting with the client and two to three followup telephone contacts that were paid for by Medicaid. Ms. Casanova explained that the State Department of Health administers the program. She added that the targeted case management services may be redundant since pregnant women are assigned to managed care organizations (MCO) that are expected to identify and manage high-risk pregnancies and that MCOs are penalized if they are not doing this. Commission members asked for the number of persons that would be impacted by this action and expressed concern that eliminating this service may result in the program spending more as a result of an increase in poor birth outcomes.

Sen. Miller announced that requests for bill drafts for the Commission's consideration should be sent to Casey Kline, attorney to the Commission, by the end of September. She requested that she be advised of the bill drafting requests, as well, in order to avoid duplication.

The meeting was adjourned at 3:35 P.M.

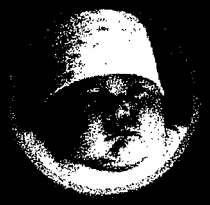
Exhibit A
Select Joint Commission on Medicaid Oversight
Meeting #2 September 14, 2011

# The Indiana Family and Social Services Administration

## Medicaid Program Integrity

## Select Joint Commission on Medicaid Oversight

September 2011



# State Agencies Involved in Provider and Member Fraud Prevention

- Family and Social Services Administration
  - Office of Medicaid Policy & Planning – Provider enrollment and payments, and member utilization
  - Division of Family Resources – Member eligibility
  - Bureau of Investigations – Member fraud
  - Division of Aging, Division of Disability and Rehab Services, and Department of Mental Health and Addiction-Waiver Services
  - FSSA Audit – Provider payments
- Attorney General
  - Medicaid Fraud Control Unit (MFCU) – Provider investigation and prosecution related to fraud

# Recoveries & Avoidances SFY 11

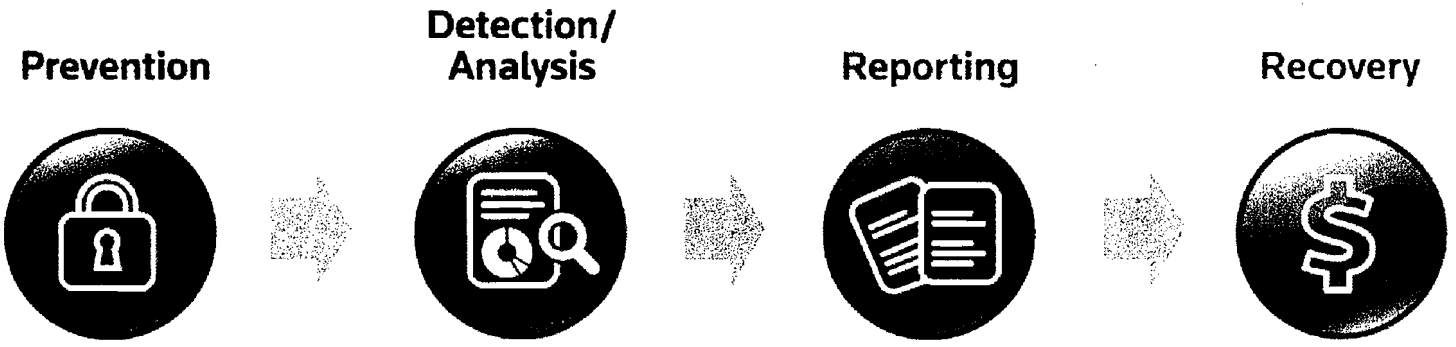
| Program | Dollars | |
|---|---|---|
| Third Party Liability | $ | 112,417,070 |
| Estate Recovery | $ | 12,199,259 |
| Pharmacy Audits | $ | 3,828,569 |
| Surveillance and Utilization | $ | 2,341,263 |
| Long Term Care | $ | 170,192 |
| **Total Program Integrity Efforts** | **$** | **130,956,353** |

# Prosecutions and Restitutions

- Member Fraud
  - Bureau Of Investigations (BOI) substantiated 138 Medicaid Fraud Cases for CY2010
  - 24 cases were prosecuted
  - 11 received felony convictions
  - Court ordered restitution totaling $24,554
- Provider Fraud SFY11
  - Medicaid Fraud Control Unit (MFCU) investigated 266 fraud referrals
  - Prosecuted 12 providers, 10 received Criminal Penalties
  - Recovered $36,098,607

# Systematic Approach to Combating Improper Payments

## FIGHTING FRAUD, WASTE, AND ABUSE



# OMPP New Program Strategy

- Expand Program Integrity Efforts in Indiana
  - Increased focus on Program Integrity
  - Collaborative Approach – Multiple agencies working alongside contractor staff
  - Coordination with all divisions before pursuing recoveries
  - Data mining in addition to reacting to referrals
  - Provider outreach, education materials, and training sessions

# Provider Improper Payments: Prevention

- Provider Education
  - Educational seminars, bulletins, and newsletters
- Provider Enrollment
  - Providers categorized by type as high, moderate, low risk
  - Screening requirements vary by risk category
  - Application fee
  - Providers rescreened at least every five years

# Provider Improper Payments: Prevention

- National Correct Coding Initiative
  - Prevent improper payments when incorrect code combinations are reported
  - More than 1.3 million new system edits in place
- Pre-payment Review
  - Validating claims before payment is made
- New ACA Regulations
  - Mandatory payment suspensions

# Member Misrepresentation and Overutilization

- Right Choices Program (RCP)
  - Identifies members who use Medicaid services more extensively than their peers.
  - Methodology:
    - Overutilization of ER, number of PMP selections, number of prescribers, and number of pharmacies
    - Overutilization of controlled substances together with multiple prescribers and pharmacies
    - Five or more psychotropic drugs in recent 45 day period
    - Benzodiazepines from three or more prescribers in recent 90 day period
    - Automatic placement due to suspected or alleged fraud
  - Outcomes
    - 38% reduction in the per member/per month spend – $257.56 -$3,000/per member per year 6000 members in RCP
    - 44% reductions in emergency room visits
    - 48% reduction in physician office visits

# Member Misrepresentation & Overutilization

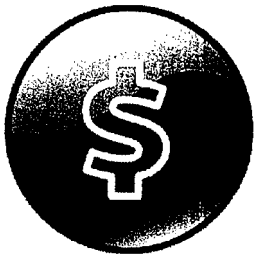
- Eligibility data matches
  - Pre-enrollment and redetermination
  - Public Assistance Information System (PARIS)
- Member fraud hotline
  - For both members and providers
- ACA eligibility data in 2014
  - Access to federal databases to validate eligibility

# Improper Payments Detection

## New Software Tools

| Tool | Purpose |
|---|---|
| i-Sight Case Tracking System | Workflow-driven solution for the documentation and tracking of all provider and member improper payments and fraud cases. |
| JSURS | J-SURS is a suite of user-friendly, claims-based, data mining software applications designed to identify potentially fraudulent, wasteful or abusive practices by both those who provide and receive healthcare services. |
| DataProbe | Powerful data exploration tool for skilled improper payments analysts used to run algorithms. |
| Medical Episode Grouper (MEG) | Used to build and analyze episodes of care and compare results across provider specialties to identify aberrant providers. |
| CLEAR | Reviews ownership and business affiliations to identify suspicious relationships among providers. |
| WestlawNext | A legal research tool used to analyze State laws, regulations and administrative codes as well as industry journals, newspapers and magazine articles. This will assist with policy reviews. |

# Improper Payments Recovery



- Recovery Audit Contractor (RAC)
  - CMS requires every State have a Medicaid RAC program
  - Medicaid RACs are contractors who audit payments made to healthcare providers to identify Medicaid payments that may have been underpaid or overpaid, and recover overpayments or correct underpayments
  - HMS will perform these services under a subcontract with the Thomson Reuters FADS
  - Initially, the RAC will assist the State in identifying and auditing providers with outstanding credit balances

# Questions

Exhibit B
Select Joint Commission on
Medicaid Oversight
Meeting #2 September 14, 2011

# Medicaid Cost Containment Initiatives

Presentation by Pat Casanova
Director of Office of Medicaid Policy & Planning

# Medicaid Budget

- Cost saving initiatives were implemented in 2010 to address a revenue shortfall in the SFY 11 Budget.

- The FY12-13 Medicaid Budget that was introduced and passed by the General Assembly had $212M in administrative savings built into the appropriation.

- If FSSA is unable to meet the savings target, the program will not have sufficient funding to pay for services in FY12-13.

- On July 1, 2011 FSSA implemented a series of additional reductions in services and provider rates in order to reach the $212M target and provide services within the appropriation.

# Medicaid Cost Components

- ***Eligibility***
  - No Reductions Allowed Due to ARRA through June 30, 2011
  - No Reductions Allowed Due to ACA through December 31, 2013
- ***Benefits***
  - Mandatory Benefits must be provided to receive Federal matching funds
  - Changes to any current Optional Benefits not required under ACA will require Legislative Action
- ***Provider Reimbursement***

# 2011 Legislative Session

- HHS Sec. Sebelius issued a letter in February 2011 to states reminding states of their flexibility to design benefits, service delivery systems and payment strategies
- Sebelius letter also recommended modifying or eliminating optional services to save money in Medicaid budgets
- Governor's Budget included language to eliminate some Medicaid optional services and granted OMPP authority to manage mental health drugs
- Budget passed by General Assembly did not include changes to optional services
- OMPP was required to achieve administrative savings through other means/programs

# Solutions

- FSSA looked to the two remaining options for cost savings – provider reimbursement and limiting services to recipients.

- OMPP regularly looks at other state's Medicaid programs, best practices, audited provider financials, potential access issues, and third party payer practices when determine policy and planning.

- OMPP consider all of these components during the development of the cost-containment initiative process.

- While these reductions have not been pleasant and we certainly understand the concerns, the overwhelming majority of providers have been very accepting of the State's financial situation and the need to reduce rates.

# Other States

- Illinois
  - Requires PA for brand medically necessary mental health drugs
  - Paying providers 90+ days after claims are submitted
- Ohio
  - New benefit limits for behavioral health services
  - 10% reduction in nursing home reimbursement
  - 6% reduction in home health reimbursement
- North Carolina
  - Elimination of eye exams and glasses for adults
  - Three physical, occupational and speech therapy visits per year
  - 9% reduction for hospital services
- Kentucky
  - Limit of four prescriptions/month for adults with a maximum of three name brand

# Provider Enrollment

| Provider Type | 1 Day Prior to Implementation of Cost Initiative | As of 9/5/2011 |
|---|---|---|
| Home Health | 206 | 221 |
| Podiatrists | 384 | 386 |
| Chiropractors | 847 | 849 |
| Optometrists | 1,012 | 1,012 |
| DME/Medical Suppliers | 1,009 | 1,003 |
| HME Suppliers | 25 | 25 |
| Dentists | 2,027 | 2,131 |
| Laboratories | 276 | 277 |
| X-Ray Clinics | 78 | 77 |
| End Stage Renal Disease Clinics | 99 | 99 |

# Emergency Rule Process

- Beginning in 2010, FSSA implemented these reductions via emergency rule while simultaneously promulgating regulations through the traditional rule process.

- This emergency rule authority has always existed for Medicaid in order for the agency to manage the program within its budget.

- Language in HEA 1001, Sec. 58, 111-112 expanded the agency's emergency rule authority by mirroring authorities of other state agencies.

# Cost Savings Initiatives

| Program Change | Effective Date | Expiration Date | Estimated Savings for SFYs 2012 & 2013 | SPA Needed |
|---|---|---|---|---|
| Inpatient Hospital 5% Rate Reduction | 1/1/2010 | 6/30/2013 | $25.6M | Yes |
| Outpatient Hospital 5% Rate Reduction | 1/1/2010 | 6/30/2013 | $11.5M | Yes |
| Home Health 5% Rate Reduction | 4/1/2010 | 6/30/2013 | $6.8M | Yes |
| Dental 5% Rate Reduction | 4/1/2010 | 6/30/2013 | $8.0M | Yes |
| Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Community Residential Facilities for the Developmentally Disabled (CRF/DD) 3% Rate Reduction | 4/1/2010 | 6/30/2013 | $6.1M | Yes |
| Developmental Disabilities Waiver Residential Habilitation 7% Rate Reduction | 6/1/2010 | Permanent | $20.3M | No |
| Elective inpatient prior authorization; all ages except newborns | 1/1/2011 | Permanent | $6.6M | No |
| Vision Benefit Changes | 1/1/2011 | Permanent | $1.2M | No |
| Transportation Rate Reduction (5% ambulance and 10% non-ambulance) | 1/1/2011 | 6/30/2013 | $4.0M | Yes |
| Chiropractic 5% Rate Reduction | 1/1/2011 | 6/30/2013 | $0.2M | Yes |
| Podiatry 5% Rate Reduction | 1/2/2011 | 6/30/2013 | $0.1M | Yes |
| Dental Cap Changed to $1000 | 1/1/2011 | Permanent | $9.4M | No |
| Aged and Disabled Waiter Attendant Care 5% Rate Reduction | 1/1/2011 | Permanent | $2.5M | No |
| Nursing Facility Leave Days Benefit Elimination | 2/1/2011 | Permanent | $1.7M | Yes |

# Cost Savings Initiatives cont'd

| Program Change | Effective Date | Expiration Date | Estimated Savings for SFYs 2012 & 2013 | SPA Needed |
|---|---|---|---|---|
| Nursing Facility 5% Rate Reduction | 7/1/2011 | 6/30/2013 | $44.8M | Yes |
| Dispensing fee lowered to $3.00 | 7/1/2011 | 6/30/2013 | $14.8M | Yes |
| Lab and Radiology 5% Rate Reduction (non-hospital only) | 7/1/2011 | 6/30/2013 | $1.0M | Yes |
| Speech and Hearing Therapy 5% Rate Reduction | 7/1/2011 | 6/30/2013 | $0.1M | Yes |
| Durable Medical Equipment/Prosthetics 5% Rate Reduction and Manually Priced Updates | 7/1/2011 | 5% Rate Reduction Ends 6/30/2013; Manual Pricing Updates are Permanent | $2.38M | Yes |
| Medical Supplies 5% Rate Reduction and Manually Priced Updates | 7/1/2011 | 5% Rate Reduction Ends 6/30/2013; Manual Pricing Updates are Permanent | $1.8M | Yes |
| Hearing Aids Rate Updates for Manually Priced Items | 7/1/2011 | Permanent | $3.1M | Yes |
| Vision 5% Rate Reduction | 7/1/2011 | 6/30/2013 | $0.5M | Yes |
| Freestanding Dialysis 5% Rate Reduction | 7/1/2011 | 6/30/2013 | $0.6M | Yes |
| Targeted Case Management Benefit Elimination | 7/1/2011 | Permanent | $0.5M | Yes |

# Questions

# Healthy Indiana Plan

September 14, 2011

# HIP

•There are currently 40,289 individuals enrolled in HIP.

•27,170 of those enrollees are parents and 13,119 are childless adults.

•FSSA has opened the waiting list for childless adults and will enroll 8,000 individuals in FY12.

•This will increase HIP expenditures through December 31, 2013 by $43.2M (state).

•8,000 notices were sent to childless adults on the waitlist in August. Since they have 45 days to respond, we will not know until early next week how many have indicated that they are still interested .

•Depending on the number of those who responded, notifications will resume in October and continue until 8,000 are enrolled.

THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

Exhibit C
Select Joint Commission on
Medicaid Oversight
Meeting #2 September 14, 2011

February 3, 2011

Dear Governor:

As the new year begins, officials at the federal and state level are looking ahead to a period full of opportunities and challenges. I have had the opportunity to speak individually with many of you over the past few weeks, including many who are now assuming their new positions. Having served as a Governor, let me welcome you to one of the best jobs you will ever have.

In these conversations, I have heard the urgency of your state budget concerns. I know you are struggling to balance your budget while still providing critical health care services to those who need them most. I want to reaffirm the Obama Administration's commitment to helping you do both.

I also know that as you prepare your budget, your attention will turn to Medicaid. Medicaid is a major source of coverage for children, pregnant women, seniors and people with disabilities in every state. It has a unique role in our health care system, covering a diverse group of beneficiaries, including some of the most frail and vulnerable Americans. And it is the nation's primary payer for long-term care in nursing homes and outside of institutions. Medicaid is a federal-state health partnership. The federal government pays a fixed percentage or matching rate and sets minimum standards. States fund their share of program costs and have the lead on designing their programs beyond these standards, including what benefits are covered, how providers are paid, and how care is delivered.

In the last two years, the Administration has worked to ensure adequate support for states to manage their Medicaid and the Children's Health Insurance Programs (CHIP). One of the first actions taken by President Obama was to work with Congress on legislation to increase federal support for the states in the form of an enhanced federal match for Medicaid (known as the Federal Medical Assistance Percentage or FMAP). This enhanced FMAP was part of the American Recovery and Reinvestment Act and lasted through December 31, 2010. However, last year, at the request of many Governors, we worked with Congress to extend the enhanced FMAP policy through June 2011. Approximately $100 billion has been provided to states, and in 2009 alone, due to the enhanced FMAP, state Medicaid spending fell by ten percent even though enrollment in Medicaid climbed by seven percent due to the recession. In addition to this financial support, we have taken many other administrative steps to open up lines of communication with states, lower the paperwork burden states face in administering the program, and accelerate our review process for state plan amendments.

We recognize that many states are re-examining their Medicaid programs and looking for opportunities to meet the pressing health care challenges and better cope with rising costs. In light of difficult budget circumstances, we are stepping up our efforts to help you identify cost drivers in the Medicaid program and provide you with new tools and resources to achieve both short-term savings and longer-term sustainability while providing high-quality care to the

citizens of your states. We are committed to responsiveness and flexibility, and will expedite review of state proposals.

Starting immediately, the senior leadership from across the Department will be available to meet individually with your staff about plans that you may already have in mind. My team stands ready to come to your state to discuss your priorities and how we can help achieve them.

In the meantime, recent conversations suggest a lack of clarity about what flexibility currently exists in Medicaid. Some of you have asked whether I can "waive" the maintenance of effort requirements for people who a state has covered under Medicaid's "optional" eligibility categories and waivers. I note that the Affordable Care Act gives a state the flexibility to reduce eligibility for non-disabled, non-pregnant adults with incomes above 133 percent of the federal poverty line ($14,500 for an individual) if the state has a budget deficit, although prior to June 30, this would mean the loss of the enhanced FMAP under the Recovery Act. I continue to review what authority, if any, I have to waive the maintenance of effort under current law.

However, states have substantial flexibility to design benefits, service delivery systems, and payment strategies, without a waiver. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services. The enclosed paper identifies a range of state options and opportunities to more efficiently manage Medicaid, many of which are underway across the country. Some of the key areas of potential cost savings are described briefly below:

- **Modifying Benefits.** While some benefits, such as hospital and physician services, are required to be provided by state Medicaid programs, many services, such as prescription drugs, dental services, and speech therapy, are optional. States can generally change optional benefits or limit their amount, duration or scope through an amendment to their state plan, provided that each service remains sufficient to reasonably achieve its purpose. In addition, states may add or increase cost sharing for services within limits (see attachment for details). Some states have opted for more basic benefit packages for higher-income enrollees (e.g., Wisconsin provides benefits equivalent to the largest commercial plan offered in the state plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty). A number of states charge beneficiaries $20 for non-urgent emergency room visits or use cost sharing for prescription drugs to steer individuals toward generics or preferred brand-name drugs. To the extent states scale back low-value benefits or add fair cost sharing that lowers inappropriate use of care, savings can be generated.

- **Managing Care for High-Cost Enrollees More Effectively.** Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures. Initiatives that integrate acute and long-term care, strengthen systems for providing long-term care to people in the community, provide better primary and preventive care for children with significant health care needs, and lower the incidence of low-birth weight babies are among the ways that states have improved care and lowered costs. For example, children's hospitals adopting a medical home model to manage the care of chronically ill

children have accomplished impressive improvements in health and reductions in cost. One Florida children's hospital reduced emergency room visits by more than one-third, and reduced hospital days by 20 percent. These delivery models and payment strategies can be implemented by hospitals and states without seeking a federal waiver, and we are exploring ways that we might provide further support for such initiatives.

In addition, the Affordable Care Act offers new Medicaid options that provide states with additional federal matching funds. For example, states can now benefit from a 90 percent federal matching rate for coordination of care services provided in the context of a health home for people with chronic conditions. Additionally, the Community First Choice Option, available in October, will offer states a six percent increase in the federal matching rate to provide certain person-centered long-term care services and supports to enhance your efforts to serve beneficiaries in community-based settings.

- **Purchasing Drugs More Efficiently.** In 2009, states spent $7 billion to help Medicaid beneficiaries afford prescription drugs. States have broad flexibility to set their pharmacy pricing. We are committed to working with states to ensure they have accurate information about drug costs in order to make prudent purchasing decisions. As recommended by states, the Department is undertaking a first-ever national survey to create a database of actual acquisition costs that states may use as a basis for determining state-specific rates, with results available later this year. Alabama, the first state to adopt use of actual acquisition costs as the benchmark for drug reimbursement, expects to save six percent ($30 million) of its pharmacy costs in the first year of implementation. We will also share additional approaches that states have used to drive down costs, such as relying more on generic drugs, mail order, management relating to over-prescribed high cost drugs, and use of health information technology to encourage appropriate prescribing and avoidance of expensive adverse events.

- **Assuring Program Integrity.** According to the Department's 2010 Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined federal and state funds were paid inappropriately. The federal government and states have a strong, shared interest in assuring integrity in every aspect of the program, and there are new options and tools available to states. Our Medicaid Integrity Institute is preparing a series of webinars for states to share best practices, learn about the potential cost savings created by the new program integrity provisions in the Affordable Care Act, and hear about initiatives underway in Medicare and the private sector that could be replicated in Medicaid. For example, to help your state identify providers who were terminated elsewhere, states will have access to a new federal portal starting in mid-February to obtain this information from other states and the Medicare program. In addition, states will be able to use federal audit contractors to save state funds and consolidate auditing efforts. States will also benefit from new, cutting-edge analytics, like predictive modeling, being developed to prevent fraud in the Medicare program. In 2010, the Departments of Health and Human Services and Justice recovered more than $4 billion in taxpayer dollars – the highest annual amount ever – from people who attempted to defraud seniors and taxpayers, and we want to continue to

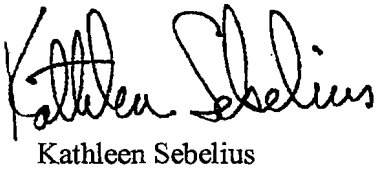
work closely with you to prevent and fight waste, fraud and abuse in Medicare, Medicaid and CHIP. The President is committed to cutting the error rate in half by 2012.

Beyond these areas of flexibility that could produce short-term savings, we are actively moving forward in areas that could lower costs in the long run. In particular, we are focused on how to help states provide better care and lower costs for so called "dual eligibles," seniors and people with disabilities who are eligible for both Medicaid and Medicare. These individuals represent 15 percent of Medicaid beneficiaries but nearly 40 percent of all Medicaid spending. This population offers great potential for improving care and lowering costs by replacing the fragmented care that is now provided to these individuals with integrated care delivery models. The new Federal Coordinated Health Care Office has already released a solicitation for up to 15 states to receive federal support to design new models for serving dual eligibles. We also plan to launch a Department-wide effort to reduce the costs of health care by improving patient safety in Medicare, Medicaid and throughout the private health care system, and states will be critical partners in this effort. We welcome other ideas on new models of care, including new ways to deliver care that encourage investment and yield savings.

To expedite these 2011 efforts, we will host a series of "virtual" meetings with state health policy advisors and Medicaid directors. In these sessions, we will share information about promising Medicaid cost-saving initiatives underway in one or more states that we are prepared to support and approve in other states on a fast-track basis.

This is just the beginning of a discussion on how we can help you better manage your Medicaid programs and navigate your budget crises. Please be assured that I am committed to working with you toward a sustainable and vibrant Medicaid system in ways that are responsive to the current challenges you are facing every day.

Sincerely,



Kathleen Sebelius

Enclosure

**Medicaid Cost-Savings Opportunities**
**February 3, 2011**

## Overview

Medicaid is a large and diverse health care coverage program. Jointly financed by the states and the federal government, in 2010, Medicaid covered nearly 53 million people and accounted for about 16 percent of all health care spending.[1] It accounts for 17 percent of all hospital spending and is the single largest source of coverage for nursing home care, for childbirth, and for people with HIV/AIDS.[2] It covers one out of four children in the nation as well as some people with the most significant medical needs.[3] While children account for most of the beneficiaries, they comprise only 20 percent of the spending. By contrast, the elderly and people with disabilities account for 18 percent of enrollees but 66 percent of the costs.[4]

Over the past three years, despite rising enrollment due to the economic recession, nationwide state spending on the Medicaid program dropped by 13.2 percent (equivalent to a 10.3 percentage point decline in the state share of the total costs of the program) as a result of the added federal support provided to state Medicaid programs through the American Recovery and Reinvestment Act of 2009 (the Recovery Act).[5] In 2009 alone, due to this action, state Medicaid spending fell by 10 percent even though enrollment in Medicaid climbed by 7 percent due to the recession.[6] However, this enhanced Federal Medical Assistance Percentage (FMAP) support is set to expire on June 30, 2011. While state revenues are beginning to show signs of recovery, the upcoming state fiscal year could be especially difficult for states.

Against this backdrop, states are beginning to plan for 2014 when Medicaid will be simplified and expanded to adults and children with income up to 133 percent of the Federal Poverty Level (FPL) ($26,645 in annual income for a family of three in 2011). Benefits for most newly eligible adults will be comparable to that of typical private insurance. Significantly, almost all of the new Medicaid coverage costs will be borne by the federal government. The Medicaid changes in the Affordable Care Act will also bring about major improvements in the program for states, health care providers, and low-income individuals. The Department of Health and Human Services (HHS), in collaboration with states, has been engaged in a multi-faceted process to accomplish these changes by 2014. The objective is to ensure that Medicaid functions as a high-performing program serving the needs of America's most vulnerable citizens and is a full partner with the Health Insurance Exchanges in achieving the coverage, quality and cost containment goals of the new law. Recent reports have found that the increased support for Medicaid, lower uncompensated care costs, and other provisions of the new law to tackle health care costs will produce savings to states as they become fully effective. In the short term, however, state budget pressures are forcing an immediate focus on this program whose enrollment has grown as job-based insurance declined due to the recession.

Now HHS is stepping up its efforts to help states consider policies that will improve care and generate efficiencies, in the short term and over time, as part of the larger imperative to tackle health care cost growth throughout the health care system. This paper identifies existing flexibility in the Medicaid program and new initiatives, many of which can be accomplished under either current program flexibilities or the new options under the Affordable Care Act.

**Existing Areas of Program Flexibility**

Over time, Medicaid has evolved to offer states considerable flexibility in the management and design of the program. States set provider payment rates and have considerable flexibility to establish the methods for payment, to design the benefits for adults, and to establish other program design features. In addition, states have the ability to apply for a Section 1115 waiver of other federal requirements to adjust coverage and payment rules.[7]

## 1. Cost Sharing

In the Deficit Reduction Act of 2005, Congress gave states additional flexibility to impose cost sharing in Medicaid in the form of copayments, deductibles, coinsurance, and other similar charges without requiring states to seek federal approval of a waiver. Certain vulnerable groups are exempt from cost sharing, including most children and pregnant women, and some services are also exempt. However, states may impose higher cost sharing for many targeted groups of somewhat higher-income beneficiaries, above 100 percent of the poverty level (the equivalent of $18,530 in annual income for a family of three), as long as the family's total cost sharing (including cost sharing and premiums) does not exceed five percent of their income.

States may impose cost sharing on most Medicaid-covered services, both inpatient and outpatient, and the amounts that can be charged vary with income. In addition, Medicaid rules give states the ability to use cost-sharing to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, such as generics, states may establish different copayments for non-preferred versus preferred drugs. For people with incomes above 150 percent of the poverty level, cost sharing for non-preferred drugs may be as high as 20 percent of the cost of the drug. The following table describes the maximum allowable copayment amounts for different types of services.

**MAXIMUM ALLOWABLE COPAYMENTS**

| **Services and Supplies (Cost Sharing Subject to a Per-Beneficiary Limit)**[a] | **Eligible Populations by Family Income**[b,c] | | |
|---|---|---|---|
| | **≤100% FPL** | **101-150% FPL** | **>150% FPL** |
| **Institutional Care** (inpatient hospital care, rehab care, etc.) | 50% of cost for 1st day of care | 50% of cost for 1st day of care, 10% of cost | 50% of cost for 1st day of care, 20% of cost |
| **Non-Institutional Care** (physician visits, physical therapy, etc.) | $3.65 | 10% of cost | 20% of cost |
| **Non-emergency use of the ER** | $3.65 | $7.30 | No limit |
| **Preferred drugs** | $3.65 | $3.65 | $3.65 |
| **Non-preferred drugs** | $3.65 | $3.65 | 20% of cost |

a. Emergency services, family planning, and preventive services for children are exempt from copayments. Cost sharing is subject to a limit of five percent of income.
b. Some groups of beneficiaries, including most children, pregnant women, terminally ill individuals, and most institutionalized individuals, are exempt from copayments except nominal copayments for non-emergency use of an emergency room and non-preferred drugs. American Indians who receive services from the Indian Health Service, tribal health programs, or contract health service programs are exempt from all copayments.
c. Under certain circumstances for beneficiaries with income above 100 percent of FPL, states may deny services for nonpayment of cost sharing.

Because Medicaid covers particularly low-income and often very sick patients, Medicaid cost sharing is subject to an overall cap. The Medicaid cost for one inpatient hospital visit averages more than $5,700 for blind and disabled beneficiaries.[8] Someone in very frail health, such as a beneficiary with advanced Lou Gehrig's disease, likely requires multiple hospital visits each year. If such an individual has four hospital stays per year and income amounting to 160 percent of poverty (about $23,000 for a family of two), without the cap he could be charged hospital cost sharing averaging up to $1,140 per visit. Total cost sharing is capped at five percent of income, so this beneficiary would not be required to pay the full 20 percent copayment for such a costly hospital stay, but could still face more than $1,100 in cost sharing per year.

## 2. Benefits

States have various sources of flexibility with respect to the design of Medicaid benefits for adults. For children, any limitations on services (either mandatory or optional) must be based solely on medical necessity; states are required to cover their medically necessary services.

**"Optional" benefits.** Medicaid-covered benefits are broken out into "mandatory" services, which must be included in every state Medicaid program for all beneficiaries (except if waived under a Section 1115 waiver), and "optional" services which may be covered at the state's discretion. Below is a table listing mandatory and optional services. While considered "optional," some services like prescription drugs are covered by all states. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services.[9]

**MEDICAID COVERED SERVICES**

| Mandatory Services (60% of Spending) | Optional Services (40% of Spending) |
|---|---|
| • Inpatient hospital services | • Prescription drugs |
| • Outpatient hospital services | • Clinic services |
| • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services | • Physical therapy |
| • Nursing facility services | • Occupational therapy |
| • Home health services | • Speech, hearing and language disorder services |
| • Physician services | • Respiratory care services |
| • Rural health clinic services | • Other diagnostic, screening, preventive and rehabilitative services |
| • Federally qualified health center services | • Podiatry services |
| • Laboratory and X-ray services | • Optometry services |
| • Family planning services | • Dental services |
| • Nurse Midwife services | • Dentures |
| • Certified Pediatric and Family Nurse Practitioner services | • Prosthetics |
| • Freestanding Birth Center services (when licensed or otherwise recognized by the state) | • Eyeglasses |
| • Transportation to medical care | • Chiropractic services |
| • Smoking cessation for pregnant women | • Other practitioner services |
| | • Private duty nursing services |
| | • Other services approved by the Secretary[a] |

a. This includes home and community-based care and other community-based long-term care services, coverage of organ transplants, Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services and other services.

**Amount, duration and scope of a benefit.** States have flexibility in the design of the particular benefit or service for adults, so long as each covered service is sufficient in amount, duration and scope to reasonably achieve its purpose.

**"Benchmark benefits."** States have broad flexibility to vary the benefits they provide to certain adult enrollees through the use of alternative benefit packages called "benchmark" or "benchmark-equivalent" plans. These plans may be offered in lieu of the benefits covered under a traditional Medicaid state plan. A benchmark benefit package can be tailored to the specific medical conditions of enrollees and may vary in different parts of a state.

Benchmark benefits coverage is health benefits coverage that is equal to the coverage under one or more of the following standard commercial benefit plans:

- Federal employee health benefit coverage – a benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider plan offered to federal employees;

- State employee health benefit coverage – a benefit plan offered and generally available to state employees in the state; or

- Health maintenance organization (HMO) coverage – a benefit plan offered through an HMO with the largest insured commercial non-Medicaid enrolled population in the state.

States may also offer health benefit coverage through two additional types of benchmark benefit plans, Secretary-approved coverage or benchmark-equivalent plan coverage. Secretary-approved coverage is any other health benefits coverage that the Secretary determines provides appropriate coverage to meet the needs of the population provided that coverage. Benchmark-equivalent coverage is a plan with different benefits, but with an actuarial value equivalent to one of the three standard benchmark plans. Benchmark-equivalent packages must include certain services such as inpatient and outpatient hospital services, physician services, and prescription drugs.

States have the option to limit coverage for generally healthy adults to benchmark or benchmark-equivalent coverage. Other groups, including blind and disabled, medically frail, and institutionalized individuals can be offered enrollment in a benchmark plan, but they cannot be required to enroll in such a plan. To date, 11 states have approved benchmark coverage. States generally have used this option to provide benefits to targeted groups of beneficiaries, rather than having to provide these services to a broader group of people. For example, Wisconsin provides benefits equivalent to the largest commercial plan offered in the state plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty.

**Opportunities for Medicaid Efficiencies**

Medicaid costs per enrollee, like those in the health system generally, are driven by utilization and payment rates, including rising prices, and to some degree by waste, fraud, and abuse. Medicaid costs are also uniquely driven by increased utilization associated with the complex cases and chronic illness prevalent among those enrolled in the program. The initiatives below aim to help states improve care and lower costs largely through changes in care delivery systems

and payment methodologies focused on the costs drivers in the program. We are developing a portfolio of approaches that would be combined with technical support and fast-track ways for states to implement the new initiatives and we remain open to other ideas that can improve care and efficiency. Most of these initiatives can be accomplished under current flexibilities under the program.

**1. Service Delivery Initiatives and Payment Strategies for Enrollees with High Costs**

Because Medicaid serves people with significant medical needs (including but not limited to "dual eligibles") and is the largest single payer for long term care, Medicaid expenditures are driven largely by the relatively small number of people with chronic and disabling conditions. For example, in 2008, five percent of beneficiaries accounted for more than half of all Medicaid spending and one percent of beneficiaries accounted for 25 percent of all expenditures.[10] Working to develop better systems of care for these individuals holds great promise not only to improve care but to reduce costs. Reducing the average cost of care by just ten percent for the five percent of beneficiaries who are the highest users of care, could save $15.7 billion in total Medicaid spending and produce a significant positive impact on longer term spending trends.[11]

Some initiatives focusing on high-need beneficiaries include:

- Care and payment models for children's hospitals to reorganize and refinance the way care is delivered for children with severe chronic illnesses. A number of children's hospitals are working to coordinate all primary care and specialized care needs of these children through a medical home model. For example, St. Joseph's Children's Hospital of Tampa reduced emergency room visits by more than one-third, and hospital days by 20 percent. The Arkansas Children's Hospital model is projected to reduce annual per child costs by more than 30 percent and reduce hospital admissions by 40 percent.[12] Even more importantly, the overall quality of life for these children can be dramatically improved through a medical home model of care.

- The "Money Follows the Person" demonstration grants extended and expanded under the Affordable Care Act. Currently, 43 states and the District of Columbia are using or planning to use these funds to help transition people from costly nursing home settings to more integrated community settings. HHS is currently exploring innovative ways for states to use these funds and welcomes state ideas. Promoting alternatives for home and community-based services reduces dependence on institutional care, improves the quality of life, and enhances beneficiary choice.

- Initiatives to change care and payment models to reduce premature births. Given that Medicaid currently finances about 40 percent of all births in the U.S., it has a major role to play in improving maternity care and birth outcomes. Early deliveries are associated with an increase in premature births and admissions to neonatal intensive care units (NICUs), which carry a high economic cost.[13] One factor contributing to premature births is an increase in births by elective cesarean section. Promising models to reduce premature births and medically unnecessary cesarean sections include adopting new protocols and using mid-level providers in an integrated care delivery setting to improve care coordination. In New York, one model of coordinated prenatal care reduced the

chances of a mother giving birth to a low-birth weight infant by 43 percent in an intervention group as compared with a group of women receiving care under standard practices.[14] In Ohio, a focus on lowering the rate of non-medically necessary pre-term cesarean deliveries has led to reductions in pre-term cesarean births and NICU admissions.[15] According to some analyses, a NICU admission increases costs ten-fold above normal delivery costs. These service delivery and payment initiatives can be accomplished without a waiver or demonstration.

- Promoting better care management for children and adults with asthma. About a quarter of all asthma-related health care spending is for hospital care, much of which could be avoided with better care management.[16] Successful models exist that involve nontraditional educators and patient self-management. A New York initiative focused on patient self-management and tailored case management reduced asthma-related emergency room visits by 78 percent.[17] A similar project in California reduced hospital admissions by 90 percent.[18]

- Initiatives to reduce hospital readmissions, which could improve care and lower costs. A recently published analysis shows that 16 percent of people with disabilities covered by Medicaid (excluding the dual eligibles) were readmitted to the hospital within 30 days of discharge. Half of those who were readmitted had not seen a doctor since discharge.[19] There is a significant body of evidence showing that improving care transitions as patients move across different health care settings can greatly reduce readmission rates. Interventions such as using a nurse discharge advocate to arrange follow-up appointments and conduct patient education or a clinical pharmacist to make follow-up calls has yielded dramatic reductions in readmission rates. One Colorado project, for example, reduced its 30-day readmission rate by 30 percent.[20] These practices can continue to be expanded in Medicaid, where the average cost of just one hospital admission for an individual with disabilities (excluding dual eligibles) is more than $5,700.[21]

- Implementing the new Health Homes option in the Affordable Care Act. This option offers new opportunities – and federal support – to care for people with chronic conditions by providing eight quarters of 90 percent federal match for care coordination services. Guidance to states has been issued (http://www.cms.gov/smdl/downloads/SMD10024.pdf), and HHS is establishing an intensive state-based peer-to-peer collaborative within the new Centers for Medicare & Medicaid Services (CMS) Innovation Center to test and share information about different models. The option, which was effective January 1, 2011, could result in immediate savings, given the enhanced match, as well as a path for learning how to establish effective care coordination systems for people with chronic conditions.

- Promoting Accountable Care Organizations (ACOs) that include Medicaid by bringing states into the planning and testing of ACO models that include, or even focus on, Medicaid plans and providers. CMS will work with states to ensure that states have ample opportunity to participate in these new models of care and benefit from any savings.

- Continuing to integrate health information technology. Health information technology (health IT) and electronic health information exchange are also key to driving down health care costs. Medicaid-financed incentive payments to eligible providers began in several states in January. HHS-funded health IT initiatives are underway in every state, providing implementation assistance and supporting improved care coordination. Additional federal grants from the Office of the National Coordinator for Health Information Technology to support state-level initiatives will be awarded in February. (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__hitech_and_funding_opportunities/1310).

**2. Purchasing Drugs More Efficiently**

Pharmacy costs account for eight percent of Medicaid program spending, with states spending $7 billion on prescription drugs in 2009.[22] While states have taken steps to reduce their pharmacy costs over the past decade, there is still strong evidence that many state Medicaid agencies are paying too high a price for drugs in the Medicaid program.[23] Recent court settlements have disclosed that the information most states rely upon to establish payment rates is seriously flawed. As a result, the major drug pricing compendium used by Medicaid state agencies will cease publication before the end of 2011, and states must find a new basis for drug pricing. We will work with states to help them manage their pharmacy costs and ensure their pharmacy pricing is fair and efficient:

- Provide states with a new, more accurate benchmark to base payments. A workgroup of state Medicaid directors and state Medicaid pharmacy directors has recommended a new approach to establishing a benchmark for rates, namely, use of actual average acquisition costs.[24] Alabama, the first state to adopt use of actual acquisition costs as the benchmark for drug reimbursement rates, expects to save six percent ($30 million) of its pharmacy cost in the first year of implementation. However, it is difficult and costly for each state to create its own data source for actual acquisition costs. States have recommended a national benchmark. In response, CMS is about to undertake a national survey of pharmacies to create a database of actual acquisition costs that states may use as a basis for determining state-specific rates. The data will be available to states later this year.

**3. Dual Eligibles**

There is great potential for improving care and lowering costs by ending the fragmented care that is now provided to "dual eligibles" – people who are enrolled in both Medicaid and Medicare. While only 15 percent of enrollees in Medicaid and Medicare are dual eligibles, four out of every ten dollars spent in the Medicaid program and one quarter of Medicare spending are for services provided to dual eligibles.[25] Fragmented care, wasteful spending, and patient harm are significant risks with two programs serving some of the most frail and medically needy people, each with its own sets of rules and disparate financial mechanisms. Just a few examples can explain the problem and suggest some of the solutions:

- When Medicaid programs invest in health homes and similar initiatives that can help people who are dually eligible avoid hospitalizations, Medicare realizes most of the savings since it is the primary payer for the cost of hospital care for these people.

- If Medicare seeks to reduce hospital costs and avoid preventable hospital readmissions, extensive discharge planning relying on the availability of community-based long-term care may be required. Those long-term care services, however, are largely driven and financed by Medicaid, not Medicare.

Except in a very small number of specialized plans covering only about 120,000 of the 9.2 million dual eligibles, people do not have a team of caregivers that direct and manage their care across Medicaid and Medicare and states do not have access to information about the care delivered across the two programs.

The Affordable Care Act establishes a new Federal Coordinated Health Care Office to focus attention and resources on improving care for dual eligibles. The Office, which was formally announced on December 29, 2010, will work with states, physicians and others to develop new models of care. In the short term, the Office will focus on the following initiatives that will have an immediate impact on states' ability to better manage care:

- Support state demonstrations to integrate care for dual eligible individuals. The Federal Coordinated Health Care Office recently announced that it will award contracts to up to 15 states of up to $1 million each to help them design a demonstration proposal to structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible individuals. Through these initiatives, we will identify and validate delivery system models that can be rapidly tested and, upon successful demonstration, replicated in other states. Further investments from the new CMS Innovation Center are under review; this is a priority area for states and HHS. Additional areas of focus and opportunity are demonstrations to decrease transfers between nursing homes and hospitals and developing accountable care organizations to serve dual eligibles and other populations with complex health problems.

- Provide states with access to Medicare Parts A, B and D data. For several years state Medicaid agencies have been requesting access to Medicare data to support efforts to: (1) improve quality; (2) better coordinate care; and (3) reduce unnecessary spending for their dual eligible beneficiaries. CMS will make these data available to states in early 2011.

**4. Improving Program Integrity**

States and the federal government share a common interest in ensuring that limited dollars are not wasted through fraud. According to the 2010 HHS Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined federal and state funds was paid inappropriately. Our work on developing new ways to prevent fraud as well as some of the new tools created by the Affordable Care Act will bring additional options and resources to states to help them with their fraud prevention and detection efforts. No waiver or special demonstration is needed to move ahead on these initiatives.

- The Medicaid Integrity Institute provides free training to state Medicaid agency staff—it conducted 38 courses last year and trained 1,900 staff since February 2008. States participate as faculty, receive training, and help shape the curriculum. We are planning a special series

of web-based trainings for state Medicaid agencies to share best practices and inform states about new provisions of the law aimed at preventing fraud.

- The Affordable Care Act requires the screening of providers and provides states with new authority to help keep problematic providers from enrolling in Medicaid. The vast majority of Medicaid providers and suppliers participate in both Medicaid and Medicare, so Medicare provider screening actions in Medicare will also benefit Medicaid and CHIP programs. A significant value for states is expected. CMS will provide active support and assistance to states, including training of state Medicaid and CHIP program staff and best practice guidelines.

- New, cutting edge initiatives are being developed to prevent fraud in the Medicare program and will be shared with states to ensure that Medicaid gets the full benefit of Medicare advances in this area including analytics such as predictive modeling to identify patterns and examine high-cost problem areas across all types of care.

- CMS will be organizing new Payment Accuracy Improvement Groups with states grouped based on their shared interest in particular program integrity vulnerabilities. States with similar interests will work with CMS, as well as federal contractors and other experts, to target issues and problem solve.

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[1] *2010 Actuarial Report on the Financial Outlook for Medicaid.* Office of the Actuary, Centers for Medicare & Medicaid Services (for enrollment data).*National Health Expenditure Projections 2009-2019.* Office of the Actuary, Centers for Medicare & Medicaid Services (for expenditure data).
[2] Kaiser Family Foundation 2010.
[3] Kaiser Family Foundation 2010.
[4] 2010 Actuarial Report on the Financial Outlook for Medicaid. Office of the Actuary, Centers for Medicare & Medicaid Services.
[5] CMS analysis of FY 2008-2010 Medicaid Budget and Expenditure System (MBES) data.
[6] Martin A. et al, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs,* 30(1): 11-22, January 2011.
[7] Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive compliance with certain specified provisions of the law or to permit expenditures not otherwise allowed under the law in the context of an "experimental, pilot of demonstration project" that the Secretary determines is "likely to assist in promoting the objectives" of the program.
[8] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.
[9] ASPE Analysis of the Medicaid Statistical Information System (MSIS) data for 2008. Spending for mandatory and optional populations.
[10] CMS analysis of FY 2008 CMS MSIS data.
[11] CMS analysis of FY 2008 CMS MSIS data.
[12] November 2010 presentation by the National Association of Children's Hospitals.
[13] Tita, A., et.al. *The New England Journal of Medicine.* January 8, 2009 volume 360, No. 2, pages 11-120.
[14] Eunju Lee, et al. *American Journal of Preventive Medicine* 2009; 36(2):154–160).
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[16] American Lung Association. Trends in Asthma Morbidity and Mortality, January 2009.
[17] Hoppin, et al, August 2010. Asthma Regional Council.
[18] Hoppin, et al, August 2010. Asthma Regional Council.

[19] *Hospital Readmissions among Medicaid beneficiaries with Disabilities: Identifying Targets of Opportunity.* Center for Health Care Strategies, December 2010.

[20] Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med* 2006 Sep25;166(17):1822-8.

[21] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.

[22] National health expenditures, historical tables. Includes state and local spending on Medicaid prescription drugs for 2009. https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

[23] See for example, OEI-05-05-00240, Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices, June 2005.

[24] *Post AWP Pharmacy Pricing and Reimbursement: Executive Summary and White Paper.* American Medicaid Pharmacy Association and the National of Medicaid Directors, June 2010. Accessed at: http://www.nasmd.org/home/doc/SummaryofWhitePaper.pdf.

[25] Kaiser Family Foundation. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*, December 2010. Accessed at: http://www.kff.org/medicaid/upload/7846-02.pdf.

**Exhibit D**
**Select Joint Commission on Medicaid Oversight**
**Meeting #2 September 14, 2011**

Deliverables from 08.23.11 Select Joint Commission on Medicaid Oversight

Rep. C. Brown

- Requested clarification on the five percent cuts to Community Mental Health Centers (CMHC).

  The Division of Mental Health & Addiction notified the CMHCs of the five percent reduction by letter on June 20, 2011. These are state dollars and not related to OMPP's budget or Medicaid cost-containment initiatives. The total savings from the reduction is approximately $5 million across 25 CMHCs.

Rep. Crawford

- Requested a copy of federal regulations pertaining to Medicaid optional services.

  Below is the federal code cite which enumerates which Medicaid services are mandatory versus optional.

  Section 1902(a)(10)(A) of the Social Security Act [42 USC 1396a(a)(10)(A)] requires states to provide the "services listed in paragraphs (1) through (5), (17), (21) and (28) of section 1905(a)" [42 USC 1396d(a)]. All other services listed are optional.

- Requested an estimate of savings accrued from coordination of payments between Medicaid & Medicaid for renal disease.

  Will share data with Commission as soon as it is available.

Rep. Crouch

- How much money from Medicaid budget was reverted at end of FY 2011?

  For SFY2011, FSSA did not have any reversion coming out of Medicaid Assistance. FSSA ended the year with a shortfall and therefore would not have had any funds available to revert.