MEDICAID COST CONTAINMENT OPTIONS FOR WASHINGTON STATE

FINAL REPORT

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EXECUTIVE SUMMARY

Like many states, Washington faces significant budget limitations brought on by the ongoing financial crisis. Medicaid accounts for about 16 percent of *near general fund-state* expenditures,[1] but program expenditures are growing much faster than the overall budget. In a prior report, researchers from George Washington University (GW) reviewed Medicaid spending and use, identifying areas that appeared to offer the greatest potential for savings. This report digs deeper into several areas identified with state officials that appear to offer the potential for viability and savings in Washington, including inpatient and outpatient hospital use and payments, emergency room use, and care management for high-risk, high-cost enrollees.

This analysis focuses on the fee-for-service portion of Washington's Medicaid program, which accounts for about 43 percent of enrollees. Fee-for-service enrollees are mostly people with disabilities and other populations that tend to have more significant physical and behavioral health needs, but also include a significant number of Medicaid-enrolled pregnant women. Managed care organizations (MCO) pay for care provided to the majority of Medicaid enrollees, but due to timing, resources and the scope of this report GW did not obtain encounter data to thoroughly examine cost savings potential under current managed care contracts, nor did GW evaluate long- term supports and services. Additional analysis of encounter data from MCOs and long-term care programs may yield more potential for savings.

Our analysis of fee-for-service Medicaid finds that small numbers of users account for most spending for inpatient and outpatient services. Persons with disabilities are frequent users, and generally among the leading drivers of spending. However, this group itself encompasses a diverse range of critical acute care needs and chronic conditions, both physical and behavioral. Pregnant women are also notable contributors to total inpatient spending. While much of this care reflects Medicaid's role in paying for nearly half of all births in Washington, high-cost cases contribute disproportionately to the overall spending on fee-for-service inpatient care for pregnant women.

Solutions that improve care, improve the health of populations and reduce per capita costs are the goal of reform efforts throughout the health care system. Unfortunately, such systems are unlikely to develop quickly enough to avert the program's current fiscal crisis. In the short term, the state will likely need to reduce costs by focusing on more blunt options offering quicker savings. Long-term solutions to bend the curve will require concentrated, coordinated care management for high-use, high-cost Medicaid enrollees, as well as payment and service delivery reforms.

Options for immediate, short term savings are limited but not unavailable. Washington can draw on its rich history of efforts to improve care and reduce costs, as well as the experiences of other states. But Washington must exercise caution: trying many different approaches could spread its resources—including personnel and funding—too thin. Any options policy makers choose to pursue should be part of a comprehensive strategy to reform payment and service delivery, addressing key issues identified here and aligning incentives for providers to control costs, encourage use of preventive services, and offer effective community-based programs to avoid higher-cost care. A clear, strategic approach that

[1] Near general fund-state (NGFS) includes the General Fund and eight related accounts: Health Services, Student Achievement Fund, Education Legacy Trust, Public Safety and Education (and its Equal Justice Subaccount), Violence Reduction and Drug Enforcement, Water Quality, and Pension Funding Stabilization.

links all initiatives together to expected outcomes and anticipated, measurable savings could provide a useful roadmap for policymakers.

Short- and long-term options discussed in this report are summarized, below.

HOSPITAL-RELATED OPTIONS

The data in this analysis and findings from a recent report by Navigant Consulting[2] identify several areas for potential cost savings related to hospital care.

A. Hospital rates

The Ninth U.S. Circuit Court of Appeals decision regarding state methodologies to reduce provider payments limits a state's ability to make arbitrary cuts to provider reimbursement, but allows for changes in reimbursement when the state provides methodology supporting the proposed change. New federal rules are forthcoming.

- The existing hospital assessment program makes cutting hospital reimbursement rates challenging, as the assessments cease if the state reduces rates below specified levels, among other conditions.[3] However, the state could amend the law to allow it to lower rates, eliminate the matching provision of some or all of the tax, or reduce inpatient rates in order to increase other rates to invest in community-based and outpatient activities that reduce or prevent hospital use.

- The assessment law includes set up of additional Quality Incentive Payments to hospitals to support evidence-based treatments, effective purchasing strategies and various quality initiatives, starting in 2013. Given the budget, those incentive payments should target strategies that reduce hospital costs, and the state should not make increased payments until cost reductions are documented. Alternatively, Quality Incentive Payment funds could be redirected to support activities that prevent avoidable hospitalizations or inappropriate ED use, as discussed later.

- For the long term, Washington may wish to re-examine its Ambulatory Payment Classifications (APC) methodology for outpatient care. According to one recent study, Enhanced Ambulatory Patient Groups (EAPG), which provide for more bundled payments than APCs, "provide the strongest cost control incentives and the highest degree of purchasing clarity."[4]

- Another long-term option may be to work with other payers in the state to negotiate hospital rates; such multi-payer rate-setting or rate negotiation could facilitate consistency in payment as reforms like accountable care organizations (ACOs) or bundled payments develop.

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[2] Navigant Consulting, Inc. (2011). *Analysis of the Washington inpatient and outpatient hospital Medicaid payment methodology.* Navigant Consulting, Inc.

[3] Washington State Legislature (2010). *House Bill Report E2SHB 2956.* Olympia, WA: Washington State Legislature. Retrieved from http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bill%20Reports/House%20Final/2956-S2.E%20HBR%20FBR%2010.pdf.

[4] Quinn, K. & Courts, C. (2010). *Sound practices in Medicaid payment for hospital care*. Hamilton, NJ: Center for Health Care Strategies. Accessed at http://www.chcs.org/publications3960/publications_show.htm?doc_id=126118

B. Focus on Adverse Events / Hospital-Acquired Infections

Reducing septicemia and other hospital-acquired infections, as well as complications from care, could help to bend the cost curve for inpatient care. Hospital acquired conditions (HACs) and adverse events are preventable actions that compromise patient care and require remediation and costs to address.

- Washington has had a reporting law for adverse events since 2006. Medicaid does not pay for adverse events identified by the Department of Health (DOH) and/or Department of Social and Health Services (DSHS) utilization review, nor does it make additional payments for services attributable to HACs. However, data challenges make it difficult to effectively capture and code those conditions.

- The Centers for Medicare and Medicaid Services (CMS) will issue final rules soon governing non-payment of adverse events in Medicaid. It is unclear whether Washington's state budget includes anticipated savings from this new provision.

C. Selective Contracting

States have rarely implemented selective contracting in Medicaid. California's Medi-Cal program is the most prominent and well-studied example; one study spanning two decades found that savings from Medi-Cal's program appeared to be a temporary phenomenon.[5] Between 1988 and 2007 Washington selectively contracted with hospitals in the large urban areas to receive non-emergency admissions and netted savings of between $7 and $12 million each year. The program ended when the state adopted new payment rates for hospitals in 2007.

- Whether or not the state wishes to return to selective contracting for hospitals, it may be an option in other services such as durable medical equipment (DME) or medical transportation.

D. Focus on Preventable Hospitalizations and Reduce Inappropriate Use of Emergency Departments

The Navigant report cited relatively high inpatient occupancy rates in Washington relative to the region.

- Further study could assess if higher rates are in part due to potentially avoidable hospitalizations, including readmissions. A recent study found that reductions in potentially avoidable hospital admissions and high-variation, high-cost outpatient services could create annual savings of more than $350 million in state expenditures in Maine.[6]

Most Medicaid patients do not use emergency departments (EDs) in a given year, but the cost per use is relatively high and small numbers of patients are frequent users. Limiting non-urgent use of EDs could provide an incentive for hospitals to educate patients and, ideally, to develop alternatives for enrollees

[5] Bamezai, A., Melnick, G.A., Mann, J.M., & Zwanziger, J. (2003). Hospital selective contracting without consumer choice: what can we learn from Medi-Cal? *Journal of Policy Analysis and Management,* 22(1), 65-84.
[6] Health Dialog (2009). *All-payer analysis of variation in healthcare in Maine.* Report to Dirigo Health Agency's Maine Quality Forum and Advisory Council on Health Systems Development. Accessed at www.mainequalityforum.gov/HDAS%20MQF%20Report_FINAL%205.1.09.pdf.

seeking primary care in EDs. In addition, the state could require that MCOs adopt similar policies in reimbursing hospitals for non-urgent ED use.

- A common way states have tried to reduce inappropriate ED use is with cost sharing. Washington's state plan allows nominal co-payments for non-urgent ED use in Medicaid, but DSHS does not apply these co-payments. Evidence that co-payments are feasible and cost-effective for non-urgent ED use is lacking, but more than 30 states have cost sharing provisions for non-urgent ED, suggesting that states find some value in their use.

- Attempting to reduce ED expenditures by targeting enrollees with high ED utilization is a strategy that Washington can implement and which could produce quantifiable savings. Federal rules allow states to limit the amount, scope and duration of services in Medicaid, including the number of ED visits. Limits can be developed in ways that accommodate EMTALA, the federal rules that require hospitals to screen all who enter the ED. Currently, eight states place explicit limits on ED use.[7]

- As noted above, Washington may be able to reduce non-urgent ED use by initiating other delivery and payment reforms. For example, the Quality Incentive Payments could be structured to provide incentives for providers to help meet needs in the community and avoid ED use by supporting telephone triage lines and more appropriate and timely access to primary care. Other states offer additional examples, as described in the full report.

TARGET HIGH-COST HEALTH CARE USERS AND DEVELOP SERVICE DELIVERY AND PAYMENT REFORMS TO MORE EFFECTIVELY MEET THEIR NEEDS

A. The Promise of Information Technology

One particularly promising tool DSHS developed in its quest to improve care management is PRISM, an electronic database of Medicaid enrollees and their utilization patterns. PRISM is already helping the state and its contractors select appropriate populations for care management by examining the patterns and prevalence of chronic conditions, clusters of conditions (co-morbidities), and medical and behavioral health utilization of high-risk, high-cost users. PRISM also allows the state to monitor subsequent care for those patients, which can help the state assess accountability of plans as more high-risk enrollees move to managed care. DSHS officials remarked that demand from providers currently overwhelms the state's capacity to fulfill all the requests.

- With the capacity to target high-cost, high-risk patients provided by PRISM, as well as its new Medicaid Management Information System (MMIS) known as ProviderOne and its new Fraud and Abuse Detection System (FADS), additional investment in staffing and/or system capacity may be essential to maximizing value—and savings—from these technologies.

[7] Kaiser Family Foundation (2009). *Benefits by service: outpatient hospital services (October 2008)* Medicaid Benefits: Online Database. Accessed at: http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=4&cat=12&sv=27.

- Washington also has experience with more traditional "predictive modeling" from its chronic care management demonstrations. As Washington develops targeted care management approaches for specific groups of Medicaid enrollees, the importance of predictive modeling is apparent.

B. Strengthen Care Management

As documented in the literature, most Medicaid members with disabilities and other high-risk, high-cost enrollees usually have multiple chronic illnesses. To generate savings, new care management programs must target the right people, rely on proven interventions, and do so at a low cost.

- Washington should continue efforts to implement broader care management for those populations, including persons with disabilities. While it is uncertain to predict savings from yet-to-be-developed programs—and the Medicaid Purchasing Authority is not assuming savings from managed care for Supplemental Security Income (SSI) beneficiaries, at least not initially—it is likely that there will be health benefits and potential cost savings from coordinated care.

- Experts maintain that states must introduce integrated management of physical and mental health services for SSI beneficiaries with severe and persistent mental illness to achieve better outcomes at more reasonable cost.[8] Members with chronic physical illnesses are more likely to be hospitalized if they also have mental health and substance abuse disorders. Washington has relatively high 30-day readmission rates, so efforts to focus on community care for these populations and divert hospitalization are important.

- The Center for Health Care Strategies has recently completed a literature review that documents interventions that appear to work and reduce costs such as primary care teams, case management, preventive home visits, transitional care and Hospital at Home. Washington's King County Partners demonstration provides an example of such an intervention.

- Washington should also continue its efforts to expand care management options for dual eligible Medicaid and Medicare beneficiaries, such as the Washington Medicaid Integration Project.

C. Continue to Improve Maternity Care

Washington has long recognized the importance of family planning and prenatal care (e.g., First Steps and the Maternal Support System (MSS)), and more recently has put forth a number of initiates to promote cost-effective birthing practices (e.g., efforts to reduce Cesarean section births; reducing the Diagnosis-Related Group (DRG) weights; and establishment of the Reducing Elective Delivery Before 39 Weeks pilot project).

Pregnant women as a group are not generally high risk or high cost, but complications and adverse outcomes such as prematurity and low birth weight incur significant immediate costs (e.g., in Neonatal Intensive Care Units (NICU) units) and long term costs for care of compromised babies.

[8] Bella, M., Somers, S.A., & LLanos, K. (2009). *Providing behavioral health services to Medicaid managed care enrollees: Options for improving the organization and delivery of services*. New York, NY: Medicaid Institute at United Hospital Fund.

- As part of budget reductions, the MSS program will target funding towards pregnant women with the highest risk of poor birth outcomes. This tiering by risk should directly address the specific risk factors for prematurity and low birth weight, and link payment to anticipated outcomes (e.g., reduced prematurity; reduced NICU use, etc.).

- Other states' experiences may inform future efforts. Hall and Berlin reported on five case studies that demonstrated an impact on preterm birth rates and improved birth outcomes in Medicaid.[9] While dated, the results bear review and are discussed in the full report.

D. Consider Palliative Care

Patients at the end of life account for significant health care costs. A recent study of four New York hospitals found that, on average, patients who received palliative care incurred $6,900 less cost per admission than those who did not get that service. Not every hospital has staff expertise or experience in palliative care. However, one possibility might be to build incentives, such as shared savings, into managed care contracts.

E. Maintain Commitment to Evidence-Based Health Policy

The state has put in place statutory and administrative tools to support evidence-based decisions for Medicaid and all of the state's publicly-financed healthcare programs. Washington's Health Technology Assessment (HTA) is not without controversy, but the opportunities it presents remain significant and will soon be joined by national efforts through the Affordable Care Act.

MAXIMIZE OPPORTUNITES AVAILABLE THROUGH THE AFFORDABLE CARE ACT

Washington is already well-positioned to take advantage of new federal opportunities like the Patient Centered Medical Home Demonstration and other opportunities resulting from the Affordable Care Act.

- The Agency for Health Care Research and Quality is launching its center for Comparative Effectiveness Research that will likely support the work of the HTA.

- The state was recently awarded federal funding for a demonstration to better manage care for dual eligibles which provides planning funds to develop an initiative that could reduce expenses of this high-risk, high-cost population.

- Additional Medicaid funding opportunities include case management for chronic illness, pediatric accountable care organizations (ACOs) and payment reforms such as bundled payment approaches.

[9] Hall, E. & Berlin, M. (2004). *Using Medicaid to support preterm birth prevention: Five case studies*. (Report to the March of Dimes) Accessed at http://www.marchofdimes.com/advocacy/prevention_pretermcasestudies.html

Reimbursement and service delivery reforms will be funded by CMS through the new Center for Innovation in Medicare and Medicaid. Already the Center is pursuing demonstrations by selecting Centers of Excellence from the provider community. These are either integrated health care systems or hospital systems that are interested in testing the new approaches.

- Washington's Medicaid program could benefit by teaming up with any Center of Excellence in the state that is a demonstration site for new approaches to reimbursement and service delivery.

I. INTRODUCTION

Washington has long been recognized as a leader in Medicaid, offering a comprehensive array of services for a significant portion of the state's low income population. But, like all states, the recession has resulted in higher unemployment, a difficult business climate, reduced taxes and as a result, lower state revenues and incomes. Medicaid is a counter-cyclical program—that is, its enrollment grows as economic hard times hit, when states are least equipped to raise revenues to support that expanded expense. The federal government provided one time relief to states, increasing their share of program expenses through higher matching rates to help weather the financial challenges of the recession. But those extra federal funds will terminate in July 2011, even as states continue to dig out from the effects of the recession and states will need to find revenues or reduce costs to meet budget gaps.

In Washington, Medicaid accounts for about 16 percent of *near general fund-state* (NGFS)[10] expenditures and, while new enrollment is a factor in program growth that puts a strain on the overall budget, it is not the only cause of growing costs. Rising health care costs are a significant factor and one that is not limited to Medicaid. "Bending the curve" of health care costs is an issue for the entire country and every health care payer, provider and consumer.

The Washington State Institute of Public Policy (WSIPP) contracted with the Department of Health Policy of George Washington University (GW) to conduct a study of Medicaid cost containment. The specific charge of the contract was to review Washington State's Medicaid program and recommend potential cost containment strategies for consideration in the 2011-13 biennium budget. GW was to accomplish this task by drawing on expert knowledge regarding health care reform and Medicaid programs in other states, with a particular focus on cost containment strategies that have a high likelihood of achieving savings that also minimize any negative impact on health care quality and access.

In an earlier report, GW identified a list of topical areas for the state to consider that appear most likely to provide opportunities for containing costs.[11] GW developed this list by reviewing the state's Medicaid budget, considering past cost-cutting measures, holding discussions with state staff and officials, assessing the state's current economic and political environment, and monitoring activities in other states. GW also reviewed the Patient Protection and Affordable Care Act (ACA) with an eye on how Washington can take advantage of the new law's provisions to engage in cost containment.

Washington Medicaid has operational and programmatic policies in place that are viewed nationally as effective tools in restraining cost growth. The state undertook a broad range of cost containment efforts in recent years, building on its Medicaid Utilization and Cost Containment Initiative (UCCI) from the early 2000's. In some areas, Washington's operations have been shown to be among the most effective in the country at cost containment, such as the outpatient pharmacy program.

[10] Near general fund-state (NGFS) includes the General Fund and eight related accounts: Health Services, Student Achievement Fund, Education Legacy Trust, Public Safety and Education (and its Equal Justice Subaccount), Violence Reduction and Drug Enforcement, Water Quality, and Pension Funding Stabilization.

[11] George Washington University Department of Health Policy. (2011). *Initial Scan of Medicaid Cost Containment Options for Washington State Medicaid*. (Report to Washington State Institute of Public Policy) Washington, DC: George Washington University. January 2011.

GW identified a few areas with greater potential for cost containment, including:

- Hospital inpatient and outpatient services;
- Emergency departments; and
- Improved care management for enrollees age 65 and older and persons with disabilities and pregnant women

This report explores these and related areas in more depth, describes cost containment options and offers a few options with potential for viability and savings. The Affordable Care Act has provisions that will affect these program areas, and its impact is part of the discussion of each option.

It is important to recognize that these program areas are not mutually exclusive. The populations receiving these services, or potentially enrolled in managed care, overlap. For example, Washington's Department of Social and Health Services (DSHS) has identified persons with mental illness as a key driver of Supplemental Security Income (SSI) disability caseload growth.[12] This high-risk population includes significant users of hospital services and emergency departments, and it could be enrolled in managed care as the state expands its offerings. Any cost containment options addressing these services must focus on this population. In addition, any change in policy regarding one of these areas may have an impact on another.

Unless otherwise noted, "Washington Medicaid" in this report includes the following:

- Individuals eligible for the complete range of medical assistance services supported by federal and state funds under Title XIX (Medicaid);
- Individuals receiving a limited set of benefits supported by federal and state funds under Title XIX (e.g., emergency medical for aliens, family planning);
- Refugees receiving benefits fully supported by federal funding under Title XIX;
- Participants in the Disability Lifeline (DL) and Alcohol and Drug Abuse Treatment and Support (ADATSA) programs previously funded entirely by state funds, but now supported by federal and state funds under a federal waiver effective January 1, 2011;
- Children's Health Insurance Program supported by Title XXI; and
- State-funded children.

[12] Mancuso, D. (2011). *Health care reform, Medicaid expansion and mental health treatment*. Presentation of David Mancuso, DSHS, before the Washington House Health and Human Services Appropriation and Oversight Committee. February 17.

II. EXPENDITURE TRENDS AND PROJECTIONS

In the first report, GW highlighted trends in actual and projected expenditures and enrollment in Washington's Medicaid program. This section reiterates some of those findings as context for the discussion that follows.

The October 2010 Medical Assistance Forecast Summary Report ("Forecast Report") from the Medicaid Purchasing Administration (MPA) indicates that total expenditures (federal and state funds) grew by 14 percent between fiscal years 2007 and 2009 (Table 1). Spending for inpatient and outpatient hospital services grew more quickly, partly due to initiatives adjusting inpatient payment rates during this time. Note that amounts in Table 1 reflect payments made by the state on a fee-for-service basis. Managed care premiums are per capita payments to managed care plans; the Forecast Report does not include data on service use by enrollees in these plans, which limits the ability of this analysis to examine any potential that may exist for cost savings in managed care.

The MPA projects total expenditures to increase by 21 percent over the 2009-11 biennium (Table 1). The highest growth rates are for hospital outpatient services, managed care, and Medicare premiums for individuals eligible for both Medicare and Medicaid ("dual eligibles"). These projections reflect anticipated changes in enrollment, use of healthcare services, and cost per unit of those services. They also reflect changes in Medicaid reimbursement and other policies legislated or enacted prior to this round of projections. For example, a hospital assessment bill (HB 2956) provided significant rate increases that augmented growth rates for inpatient and outpatient services in 2009-11.

Looking ahead, the MPA projects total expenditures to grow from $4.8 billion in 2011 to $5.5 billion in 2013, a total increase of 15 percent for the biennium (Table 1). Most service categories have similar projected growth rates. The two categories expected to grow most rapidly are Medicare premiums for dual eligibles, and payments for prescription drugs. Much of the increase for prescription drugs is due to the phased-down state contribution to the Medicare drug benefit (Part D) to help offset the federal costs of covering dual eligibles, often termed the "clawback."[13] Washington has little control over costs for either Medicare premiums or the clawback.

[13] Washington paid lower monthly amounts to the federal Medicare program in the 2009-11 biennium because of increased federal matching levels enacted in the American Recovery and Reinvestment Act of 2009 (ARRA). The expiration of the increased matching rates results in a very high projected growth rate for clawback payments (over 40%) in the 2011-13 biennium. Excluding the clawback, the MPA projects expenditures for prescription drugs will grow by 14 percent over the 2011-13 biennium, much closer to the average rate for all services.

TABLE 1: WASHINGTON FEE-FOR-SERVICE MEDICAID EXPENDITURES FOR SELECTED SERVICE TYPES, ACTUAL AND PROJECTED, FY2007 TO FY2013

Service Type	Expenditures (in millions)				% Change		
	FY2007 (actual)	FY2009 (actual)	FY2011 (est.)	FY2013 (est.)	FY07-FY09	FY09-FY11	FY11-FY13
Hospital – Inpatient	$591	$717	$883	$992	21%	23%	12%
Hospital – Outpatient	$246	$285	$373	$423	16%	31%	13%
Physicians & Other LHCP[A]	$610	$681	$839	$924	12%	23%	10%
Managed Care Premiums	$1,163	$1,303	$1,681	$1,926	12%	29%	15%
Medicare Premiums[B]	$191	$229	$364	$461	20%	59%	27%
Prescription Drugs[C]	$416	$453	$375	$466	9%	-17%	24%
Durable Medical Equipment	$110	$126	$120	$135	15%	-5%	12%
Other Services[D]	$124	$149	$147	$171	20%	-2%	16%
Total Expenditures[E]	**$3,451**	**$3,944**	**$4,783**	**$5,498**	**14%**	**21%**	**15%**

Source: Medical Assistance Forecast Summary Report, October 2010

Notes: [A] Other licensed health care providers (LHCP) include various clinics, lab/x-ray, dental, optical, hospice and home health services.

[B] Medicaid pays some Medicare costs (premiums and/or co-payments) for individuals eligible for both Medicare and Medicaid ("dual eligibles").

[C] Expenditures for prescription drugs are net of manufacturer rebates, and include "clawback" payments to the federal government for the Medicare drug benefit (Part D).

[D] Other services include various support and contracted services; transportation is the largest component.

[E] Excludes long-term care services (e.g., nursing facility, personal care, and other services provided by other agencies), disproportionate share hospital (DSH) payments and program administration.

Table 2 shows how much each service type contributes to the total change in expenditures during each period. Managed care premiums accounted for almost 30 percent of the total growth from FY2007 to FY2009, and MPA expects these services to account for larger shares of total growth between FY2009 and FY2013. Much of the projected growth in managed care spending from FY2009 to FY2013 reflects expected increases in enrollment. Rising enrollment also influences spending for services other than managed care, and expected changes in the use of services and cost per unit of service also contribute to the overall trend. Hospital inpatient and outpatient services (combined) accounted for about one-third of total expenditure growth between FY2007 and FY2009, and MPA projects that these services will account for about 30 percent of growth from FY2009 to FY2011, and 22 percent of growth from FY2011 to FY2013 (Table 2).

The accuracy of enrollment and expenditure forecasts is important, as these forecasts feed directly into the state's budget process for Medicaid. Officials we talked with broadly view the MPA's estimates as accurate, and some characterized their estimation process as the "gold standard" in the state. However, there is always uncertainty in projecting future trends and the volume of Medicaid expenditures means that even small percentage differences can be large dollar amounts. Inaccuracies tend to be largest when there are significant changes to underlying policies or payment systems, or external influences (such as the recent recession) that are hard to predict. Officials also noted that Medicare premiums and clawbacks tend to be harder to estimate, especially several years out.

TABLE 2: COMPONENTS OF TOTAL EXPENDITURE CHANGE BY SERVICE TYPE, FY2007 TO FY2013

Service Type	% of Total Change in Expenditures		
	FY07-FY09 (actual)	FY09-FY11 (est.)	FY11-FY13 (est.)
Hospital – Inpatient	26%	20%	15%
Hospital – Outpatient	8%	10%	7%
Physicians & Other LHCP[A]	14%	19%	12%
Managed Care	28%	45%	34%
Medicare Premiums[B]	8%	16%	14%
Prescription Drugs[C]	8%	(-9%)	13%
Durable Medical Equipment	3%	(-1%)	2%
Other Services[D]	5%	< 1%	3%
Total Expenditures[E]	**100%**	**100%**	**100%**

Source: Medical Assistance Forecast Summary Report, October 2010

Notes: Numbers in parentheses [e.g., (-$2)] are negative values representing decreased expenditures.

[A] Other licensed health care providers (LHCP) include various clinics, lab/x-ray, dental, optical, hospice and home health services.

[B] Medicaid pays some Medicare costs (premiums and/or co-payments) for individuals eligible for both Medicare and Medicaid ("dual eligibles").

[C] Expenditures for prescription drugs are net of manufacturer rebates, and include "clawback" payments to the federal government for the Medicare drug benefit (Part D).

[D] Other services include various support and contracted services; transportation is the largest component.

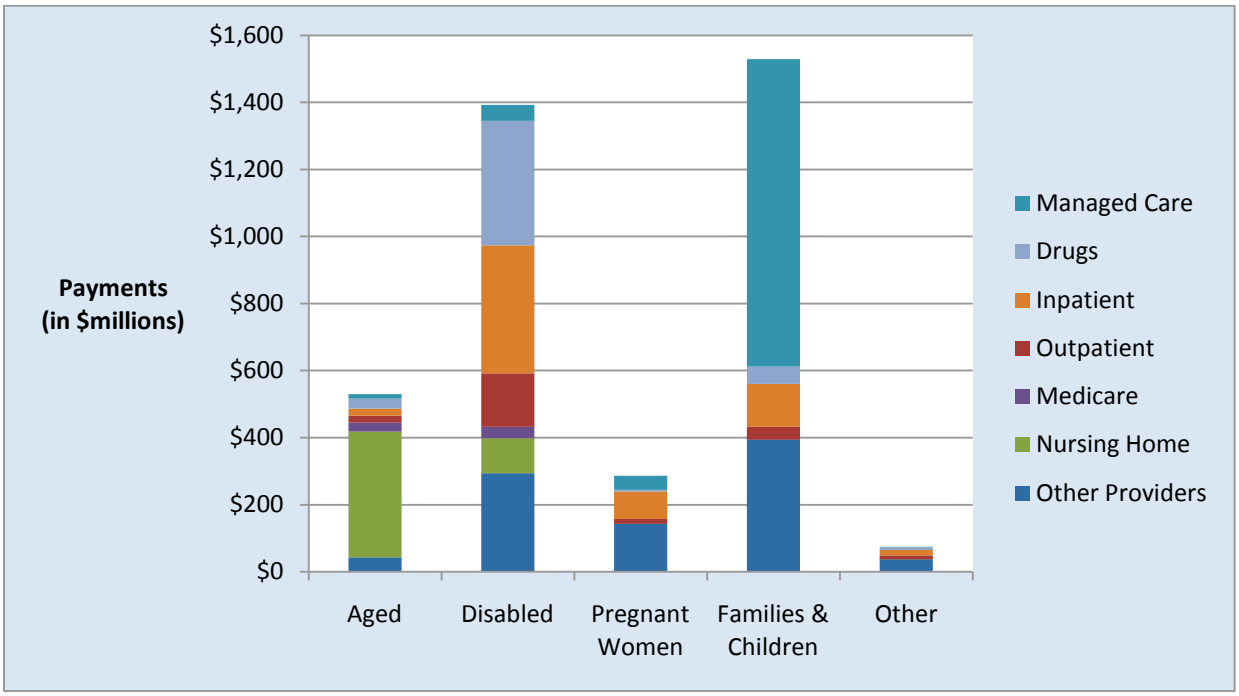
[E] Total expenditures exclude long-term care services (e.g., nursing facility services, personal care, and other services provided through other agencies), disproportionate share hospital (DSH) payments and program administration.

Roughly 57 percent of enrollees in Washington Medicaid are in comprehensive managed care plans; virtually all are nondisabled adults and children, based on the eligibility coding for Medicaid. The main managed care program is Healthy Options, which covers four eligibility groups: categorically needy families (about 80% in managed care) and children (about 75% in managed care), categorically needy pregnant women (about 40% in managed care), and children in CHIP (about 85% in managed care).[14] There are several services excluded from the standard per-member, per-month rates paid to managed care organizations (MCOs), including (but not limited to) approved surgical procedures for weight loss or reduction, health care services for children at neurodevelopmental centers, transportation services other than ambulance, and certain prescriptions. There is also a one-time payment for labor and delivery expenses when the MCO pays these childbirth expenses. A small number of individuals aged 65 and older and persons with disabilities are in managed care under the Washington Medicaid Integration Project (WMIP) pilot. Most Disability Lifeline enrollees are also in managed care, but this plan excludes hospital inpatient and outpatient services and some other services which remain the state's responsibility in fee-for-service.

[14] Percentages of enrollees in managed care provided by DSHS

Data provided to GW by DSHS show that most Medicaid spending for families and children goes to managed care (Figure 1). Although DSHS requires contracted managed care organizations (MCOs) and Regional Support Networks (RSNs) to report encounter data for healthcare and mental health services delivered to enrollees, neither the MPA forecast nor the DSHS data provided to GW allow examination of service use within MCOs. Encounter data are available for research, subject to client confidentiality and DSHS research review protocols; in-depth analysis of those data would allow a more granular understanding of health care expenditures and could help to identify and/or evaluate cost containment strategies within Medicaid managed care.

FIGURE 1: FEE-FOR-SERVICE PAYMENTS BY ELIGIBILITY GROUP AND SERVICE TYPE, FY2009



Source: GW analysis of Medicaid data provided by DSHS

Notes: "Other Providers" include physicians and other licensed health care providers, dental, medical vendors, and early and periodic screening, diagnosis and treatment (EPSDT) services. "Aged" includes program codes for Aged and Institutional Aged. "Disabled" includes program codes for Blind, Disabled, and Disability Lifeline (GAU and GA-X/Expedited (Presumptive SSI)). "Families & Children" includes program codes for AFDC-R/TANF, Foster Care/Adoption, and Children's. "Other" includes program codes for Family Planning, Breast/Cervical Cancer, Medically Indigent, Mental Health ITA, Refugee, ADATSA, and State-funded Children.

Limits of this Analysis

This report does not evaluate two of the largest expenditure components in Washington Medicaid: long-term supports and services and managed care. Long-term care related services are both managed and reported on separately from most Medicaid services. With the exception of nursing home spending shown in Figure 1, we did not have access to data on long term-care supports and services. These types of services were not a focus of our meetings with state officials and stakeholders, and were not identified by them as an area of interest for this report.

Managed care growth, as reported in Table 1 and 2, is clearly worthy of more review but requires more information than presently available to understand projections of enrollment and costs and what drives costs. Encounter data, as noted above, would be critical to that review as would a more thorough assessment of how rates are set and negotiated. Medicaid MCO payments are of growing interest to states around the country. In Minnesota, the state is calling for more transparency and review of its MCOs, triggered in part by the recent refund from reserves of $30 million to the state by UCare, a non-profit Medicaid and Medicare health plan. MCO rates may need adjustment, as many new enrollees joining Medicaid during the recession may be healthier and/or have fewer unmet needs than the existing population upon which rates are generally predicated, given many of the new enrollees likely had higher incomes and other forms of health insurance before falling on hard times.

III. OVERVIEW OF COST CONTAINMENT STRATEGIES

Options available to Washington to offset the expected budget shortfall for the 2011-13 biennium and to control growth of the Medicaid program moving forward fall into a number of categories:

- Reduce or freeze provider payments;
- Reduce Medicaid benefits;
- Reduce Medicaid eligibility;
- Increase costs to patients;
- Better manage care to control costs; and
- Payment reform to incentivize more efficient and effective service delivery.

This section of the report summarizes each of these approaches, and notes which options may be more (or less) suitable for Washington's current budget. Opposition to any of these options can be expected from consumer groups and providers, and reflects the challenges faced in balancing the budget. Any of these options also has potential consequences in other areas of the Medicaid budget, or in spending for other state or local government programs. For example, cuts or restrictions resulting in unmet needs or delayed care can result in more serious illness or an increase in costs and uncompensated/charity care demands on providers and local health departments.

REDUCING OR FREEZING PROVIDER PAYMENTS: Reimbursement is usually one of the first places states look to achieve cost savings in Medicaid. Officials generally view changes in reimbursement as being more straightforward to implement than service delivery reforms. Savings are normally predictable. Conversely, states must balance these payment reductions to assure they are not so significant that they lead to significant diminution of access for enrollees if providers choose to exit the program or otherwise limit their participation.

One of the challenges to containing costs through cuts to provider reimbursement comes from a court ruling last year by the Ninth Circuit Court of Appeals. In the case of *Independent Living Center of Southern California v. Maxwell-Jolly*,[15] the court ruled on a California law that attempted to lower reimbursement rates for non-hospital providers. The court ruled that 10 percent rate reductions for all Medicaid providers except hospitals, as mandated by legislative action, should be enjoined because the state did not base the adjustments on detailed cost studies showing that the resultant rates were reasonably related to the providers' costs of providing the services.

It is equally important to review the amicus brief filed by the federal Department of Health and Human Services and to recognize that guidance will be forthcoming from CMS regarding how Washington can best meet the federal requirements that states must:

[15] *Indep. Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly*, 590 F.3d 725 (9th Cir. 2009)

> "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan… as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. §1396(a)(30)(A)

In its Amicus brief, HHS states, "there is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs and §1396(a)(30)(A) does not set forth any requirement that a state consider cost studies in setting rates… to be sure provider rates affect provider participation. But there is no requirement… (to pay costs)… in order to ensure reasonable access to quality of care." The brief notes that the issue is best left to regulatory interpretation and asserts that HHS will have a proposed rule in April 2011 and a final rule in December 2011 to clarify how states should meet the intent of §1396(a)(30)(A). Washington has actively encouraged HHS to expedite guidance in this area.[16]

In short, changing provider reimbursement is an option that remains available to Washington. However, this approach requires careful planning and evaluation to maximize the likelihood that such changes will receive approval from CMS and minimize the potential for successful legal challenges.

REDUCING MEDICAID BENEFITS: Eliminating or restricting use of services is another approach used by states seeking to control costs. Federal requirements specify that states participating in Medicaid must offer several types of services to enrollees, including (but not limited to) inpatient and outpatient hospital, physician, laboratory and radiological, skilled nursing facility services for persons over age 21 and home health care services for persons over 21 who are eligible for skilled nursing services.[17] States may also choose to cover a variety of optional services, which include (but are not limited to) dental services, physical therapy, prescribed drugs, prosthetic devices, transportation services, hospice care and home and community-based services for persons with disabilities and chronic medical conditions.[18]

This option is also available to Washington. Effective January 1, 2011, the state cut several services to address shortfalls in the current budget, including:

- Non-emergency adult dental coverage;
- Hearing aids, cochlear implants, and bone-anchored hearing aids;
- Adult podiatry that is not medically necessary to treat an acute condition;
- Eyeglasses (frames and lenses) for adults;
- School-based medical services for children in an Individualized Education Program (IEP); and
- Prescription co-payments for dual eligibles in the Medicare drug benefit (Part D).[19]

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[16] Gregoire, Gov. C. & Brown, Gov. J. (2011). Letter to the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services. February 23, 2011.
[17] 42 C.F.R. §440.210 – 42 C.F.R. §440.220
[18] 42 C.F.R. §440.225
[19] Washington Department of Social and Health Services (DSHS). (2010). *Some Medicaid program budget cuts avoided, but most adult clients will lose vision, hearing, dental services Jan. 1*. Olympia, WA: DSHS. Retrieved from http://www.dshs.wa.gov/mediareleases/2010/pr10109.shtml.

Governor Gregoire's proposed budget for the 2011-2013 biennium included cuts to optional benefits for certain Medicaid-eligible populations, including interpreter services for non-English speaking Medicaid patients, and extending the cuts for Medicare Part D drug co-payments, adult podiatry, and school-based Medicaid services to students in special education.[20]

REDUCING MEDICAID ELIGIBILITY: Federal requirements specify that to receive federal funding, states must enroll persons from certain low-income groups such as (but not limited to) children and pregnant women, parents/caretaker adults in low-income families, and recipients of Supplemental Security Income (SSI).[21] Many states, including Washington, extend coverage to optional eligible groups for which they receive federal funding. These include (but are not limited to) children, pregnant women and parents with somewhat higher incomes, individuals with higher incomes who are in nursing facilities or using home- and community-based services in lieu of nursing facilities, and individuals with high health care costs who "spend down" to become eligible.[22] During past fiscal crises, states reduced eligibility among these optional populations as a means of limiting growth, although Washington has generally avoided eligibility reductions.

In order to retain Medicaid enhanced funding, the Affordable Care Act requires that states maintain existing Medicaid eligibility levels as of March 23, 2010, for adults until the state's health insurance exchange is fully operational (likely January 2014) and for children (including Medicaid and the Children's Health Insurance Program (CHIP)) through federal fiscal year 2019. However, federal rules allow exemptions from the maintenance of effort provisions for non-disabled adults above 133 percent of the federal poverty level from 2011 to 2013, if a state certifies it is experiencing a budget deficit or will experience a deficit in the following year, and CMS has signaled to states that its Section 1115 waiver authority allows the federal government to consider additional changes to maintenance of effort, should states seek or amend such waivers.

The state would need to seek CMS clarification on any cuts to eligibility; however, it appears that the state may cut eligibility for participants in fully state-funded programs. The Children's Health Program, which serves mainly undocumented children, is the most likely option for cuts. Although there were proposals in 2010 to cut the state-funded Disability Lifeline and Basic Health programs, Washington received a federal waiver effective January 1, 2011, that made these programs (and ADATSA) eligible for federal match. The waiver does allow DSHS to freeze new enrollment in these programs and to establish waiting lists.

INCREASING COSTS TO PATIENTS: Federal requirements allow states to apply cost sharing, in the form of "nominal" co-payments, to certain Medicaid populations. States cannot require cost sharing for persons eligible under mandatory groups. Moreover, generally providers may not refuse services to Medicaid enrollees based on inability to pay. These provisions limit the scope and effectiveness of co-payments, but they are still common in many Medicaid programs. Washington does not currently use co-payments in Medicaid, but they are an option under consideration for the 2011-13 budget.

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[20] Gregoire, Gov. C. (2010). *Proposed 2011-13 budget & policy highlights: transforming Washington's budget*. Olympia WA: Office of the Governor. Retrieved from http://www.governor.wa.gov/priorities/budget/press_packet.pdf.

[21] 42 C.F.R. §435.100 – 42 C.F.R. §440.170

[22] 42 C.F.R. §435.200 – 42 C.F.R. §440.350

Research on the effectiveness of co-payments as a cost containment tool is mixed. The Rand Health Insurance Experiment found that co-payments led to larger reductions in use of medical care by low-income adults and children than by those with higher incomes.[23] A study of low-income adults receiving welfare in Quebec found that co-payments for prescription drugs lowered use of medications and led to increases in hospitalization and emergency room use.[24] One study from Oregon found that co-payments led to significant reductions in use of clinically important drug classes but did not appear to effect use of emergency departments, office visits, or hospitalizations.[25] Another study did find changes in treatment patterns in Oregon, but found that the co-payments did not provide expected savings.[26]

In general, while co-payments may lead to cost savings, those savings arise from potentially undesirable outcomes: (1) reduced reimbursement to providers because of unpaid co-payments, and (2) delayed or foregone use of healthcare services by enrollees, which could potentially result in higher costs in other areas. On the other hand, modest co-payments ($1-$3) are common now in Medicaid and might not be problematic for most doctor visits. Higher co-payments are also feasible for emergency department visits or other services where reductions in inefficient or inappropriate use may be desirable, if there are adequate efforts to assure appropriate access and referral to other care sources.

BETTER CARE MANAGEMENT: It has been widely asserted that fee-for-service health care is inefficient, rewards providers for providing more care, and generates more wasteful payments compared to "managed care." Managed care programs take on many forms. Broadly defined, it includes:

> …plans intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.[27]

"Bending the curve" in healthcare spending involves, among other things, improved care management. Washington is widely recognized as a leader in innovative care management practices in Medicaid. At the same time, opportunities remain available in the state to improve management in ways that should

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[23] Newhouse, J. (1996). *Free for all? Lessons from the Rand Health Insurance Experiment.* Cambridge, MA: Harvard University Press.

[24] Tamblyn, R., Laprise, R., Hanley, J. A., Abrahamowicz, M., Scott, S., Mayo, N., . . . Mallet, L. (January 24/31, 2001). Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA: The Journal of the American Medical Association, 285*(4), 421-429. doi:10.1001/jama.285.4.421

[25] Hartung, D. M., Carlson, M. J., Kraemer, D. F., Haxby, D. G., Ketchum, K. L., & Greenlick, M. R. (2008). Impact of a medicaid copayment policy on prescription drug and health services utilization in a fee-for-service medicaid population. *Medical Care, 46*(6), 565-572. doi:10.1097/MLR.0b013e3181734a77

[26] Wallace, N. T., McConnell, K. J., Gallia, C. A., & Smith, J. A. (2008). How effective are copayments in reducing expenditures for low-income adult medicaid beneficiaries? Experience from the Oregon Health Plan. *Health Services Research, 43*(2), 515-530. doi:10.1111/j.1475-6773.2007.00824.x

[27] U.S. National Library of Medicine. (2011). *2011 medical subject headings (MeSH)*. Bethesda, MD: National Institutes of Health. Retrieved from http://www.nlm.nih.gov/mesh/MBrowser.html

lead to better health outcomes and potentially lower costs. Evaluation of available encounter data could help to identify and/or evaluate cost containment strategies in managed care.

LONG-TERM PAYMENT REFORM EFFORTS TO INCENTIVIZE MORE EFFICIENT AND EFFECTIVE SERVICE DELIVERY: Broader, long-range efforts to develop and adopt payment reforms that support efficient and effective service delivery are worth pursuing. There is a growing appreciation nationally that rising health care costs often reflect inefficiencies in the delivery of service. Those inefficiencies can result from historic payment mechanisms that may reward more costly service and disallow reimbursement for less costly or more effective alternatives and may support volume over value. That is, payment can encourage more and more service and not necessarily the most appropriate service to meet a need. High rates of potentially avoidable hospitalizations, for example, may best be prevented by redirecting funding from hospitals to better management of chronic illness or expanded hours of access to primary care. Achieving that change, however, requires restructuring what and how Washington pays for care.

Washington has begun an important initiative through its all-payer Patient-Centered Medical Home Demonstration. By incentivizing primary care practices to better manage patient care, these demonstrations hope to begin the work of redirecting how and where care is provided to increase quality and reduce costs. Given the increasing costs in the State for care for those dually eligible for Medicare and Medicaid, the state's application for a federal demonstration to restructure care for the dual eligibles also holds promise, should the state be selected in this highly competitive review.

On April 5, 2011, the Innovation Center at CMS announced that Washington would receive a $1 million grant under the Affordable Care Act to integrate care for dual eligibles. Under this grant, the state will produce a multi-phase plan to better serve dual eligibles and reduce the cost of health care for this generally high-cost population: First, by adding dual eligibles into existing chronic care management models; Second, by exploring the inclusion of this population into Medicaid managed care; and lastly, by continuing the development of fully integrated systems of managed care. DSHS officials believe that implementation of the plan will provide shared savings opportunities for both Medicaid and Medicare.

The Affordable Care Act provides other opportunities in payment reform including Medicaid management of chronic illness, bundled payments to improve care and reduce inappropriate hospitalizations; global payments for safety net hospitals and the opportunity to experiment with emerging accountable care organization models for pediatric providers. The Affordable Care Act also provides grants to test new methods to address medical malpractice.

Finally, there is growing interest nationally in improving data and reporting on payments to MCOs. As noted earlier, this report does not assess if there are any potential savings possible in existing managed care programs. Thorough analysis of encounter data from MCOs could identify additional areas for cost containment. CMS has launched an initiative to require states to submit encounter data to them;[28] DSHS indicates that Washington meets the current CMS standards. Similarly, DSHS reduced some MCO premiums in 2010 because of low medical loss ratios, however loss ratios focus on what percentage of total payments can go to administration and do not necessarily address overall trends in service utilization or costs. Minnesota is engaged in a managed care review that includes examining the levels of reserves held by managed care companies who serve large numbers of Medicaid enrollees.

[28] Medicaid and CHIP Payment and Access Commission (MACPAC) (2011). *Report to the Congress on Medicaid and CHIP.* Washington, DC: MACPAC. March. Retrieved from http://www.macpac.gov/reports.

IV. HOSPITAL PAYMENTS AND UTILIZATION

Washington has been a leader in advancing payment reforms for Medicaid hospital reimbursement. The state uses an All-Patient Diagnosis-Related Group (DRG) method to pay for most inpatient care and an Ambulatory Payment Classification (APC) for outpatient services. According to DSHS staff, the current payment methods contain more incentives to minimize expenditures than did previous systems. Still, payment rates have been a concern for many officials. Hospital services have been and continue to be among the fastest-growing expenditure categories (see Table 1, above) and noteworthy contributors to overall expenditure growth (see Table 2, above).

In 2009, the Washington legislature enacted a 4.3 percent cut in payments to hospitals, which was projected to generate savings of $217 million. To elude these cuts, the Washington State Hospital Association worked with the legislature and DSHS to create a Hospital Safety Net Assessment Program. Funds collected through hospital assessments provided state funds necessary to prevent the cuts and to obtain more federal Medicaid matching funds. Enacted in the spring of 2010, it restored the 4 percent reduction retroactively and funded additional inpatient rate increases that average about 10 percent, depending upon the type of hospital. Rates for outpatient services also increased significantly.

Payments to hospitals continue to draw the attention of state officials, as evidenced by a recent report on hospital payment rates by Navigant Consulting, commissioned by the legislature.[29] The results of the study suggest that Washington's hospitals offer sufficient capacity/access for Medicaid enrollees, although availability of psychiatric beds may be somewhat limited; that quality of care in Washington's hospitals is consistent with hospitals nationwide; and that overall inpatient and outpatient payment levels do not appear to have significantly affected access to or quality of hospital services in the state. Most of the quality and access measures considered by Navigant predate the rate increases under the assessment program. Navigant states that,

> "When comparing Medicaid payments to what Medicare would have paid for the same services, our analysis shows that, for Medicaid inpatient acute services, Medicaid would pay slightly more than Medicare. Our analysis also shows that for outpatient services, Medicaid pays PPS hospitals more than Medicare would pay, although less than Medicare for the State's CPE hospitals."[30]

Using hospital financial data from Washington's Department of Health, Navigant shows that most of Washington's hospitals turned profits in 2009 and most had positive operating margins. Among the 27 in-state hospitals with over 5,000 Medicaid days, three reported net losses and one of those had a negative operating margin.[31] In aggregate, average operating margins and total margins for Washington hospitals are increasing.[32]

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[29] Navigant Consulting, Inc. (2011). *Analysis of the Washington inpatient and outpatient hospital Medicaid payment methodology.* Navigant Consulting, Inc.

[30] Ibid.

[31] Ibid.

[32] Washington Department of Health (2010). *hospTRENDS*. Volume 2010-4, October. Pp 10-11. Operating margin includes revenue from patient care and other operating revenue. Total margin includes operating margin plus extraordinary items, federal income taxes and non-operating income.

A recent report by the Center for Studying Health Systems Change also found that while the hospital market in the Seattle area has historically been less concentrated than in other metropolitan areas, circumstances are changing and hospital competition is leading to more consolidation among hospitals and with physician groups.[33] There is a risk this will lead to rising hospital costs in the market, although that is not clear at this time. Conversely, consolidation could lay the foundation for the emergence of accountable care organizations, but issues of diminished competition and consolidated bargaining power will still need to be addressed to assure appropriate reimbursement and costs.

INPATIENT CARE

Summary of Hospital Inpatient Use and Payments

Data provided by DSHS included hospital inpatient service claims totaling $530 million for FY2008 and $629 million for FY2009. Using de-identified but unique identifiers, GW counted approximately 39,900 unique users of inpatient services in FY2008 and 45,700 users in FY2009. These payment and utilization levels translate to an average (mean) annual cost of about $13,500 per user over the two-year period.[34] Small numbers of very high-cost users disproportionately drive up the average; median payments are considerably less (Table 3). These data reflect claims for fee-for-service users only; GW did not have access to data on inpatient encounters for patients in managed care plans.

TABLE 3: SUMMARY OF FEE-FOR-SERVICE HOSPITAL INPATIENT USE AND PAYMENTS

Measure	FY2008	FY2009	% Change
Total amount paid	$530 million	$629 million	19%
Unique users	39,885	45,725	15%
Average (mean) per user	$13,287	$13,763	4%
Median per user*	$5,273	$5,265	0%

Source: GW analysis of Medicaid data provided by DSHS

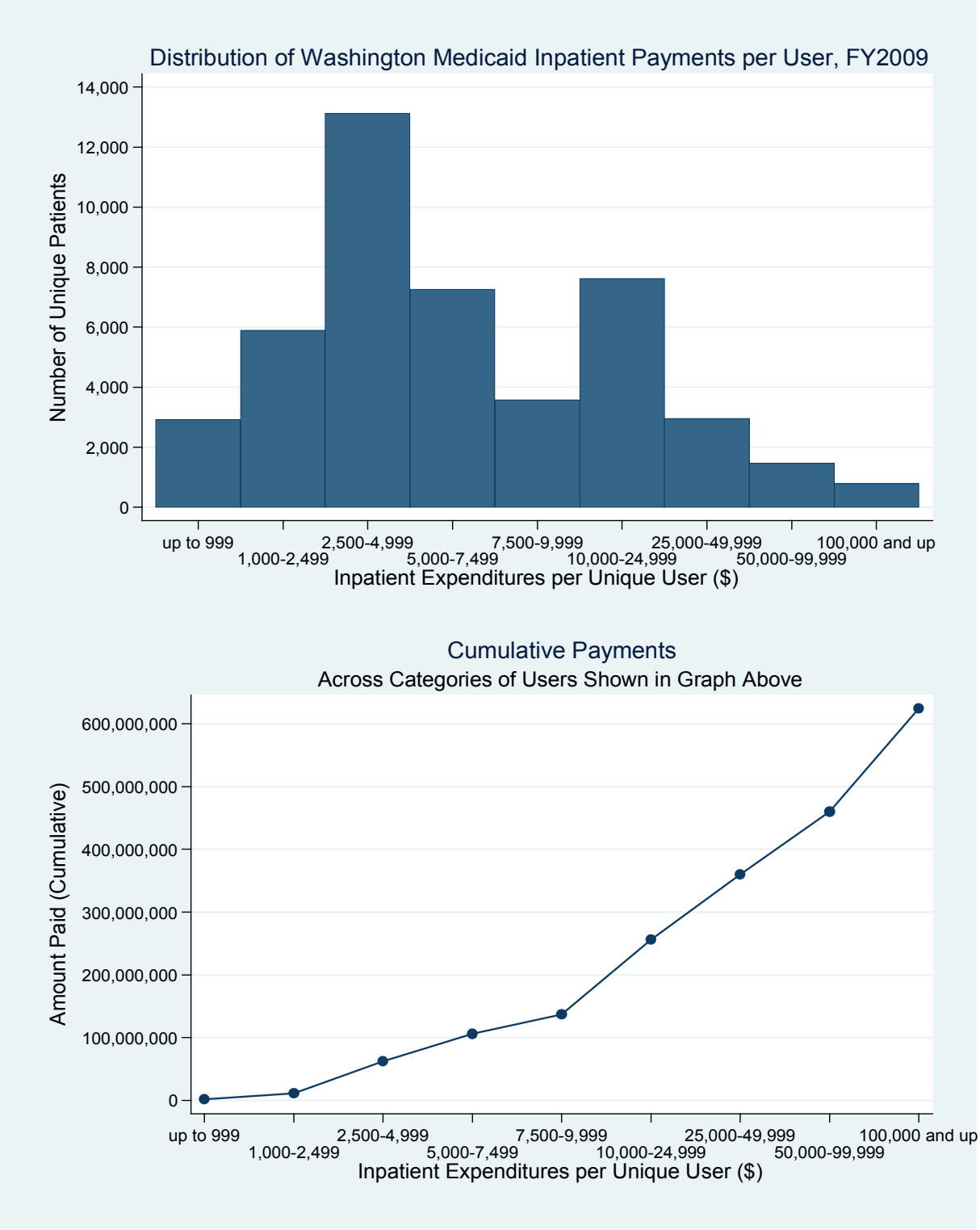
* The median is the mid-point of the distribution; half of all users have total payments that are higher than the median, and half of all users have total payments that are below the median.

Figure 2 highlights the fact that the distribution of payments for inpatient services is highly skewed, with small numbers of recipients having very high levels of spending. The bottom chart in the figure shows how much each group of users in the top chart contributed to the $629 million in cumulative inpatient payments in FY2009. Together, the charts demonstrate that a minority of high-cost users generate the majority of payments for inpatient hospital services. The following sections look more closely at the characteristics of some of these high-cost users.

[33] Hill, I., Berenson, R.A., Christianson, J.B., Dowling, M.K., Mayrell, R.C., & Yee, T. et al (2010). *Seattle hospital competition heats up, raising cost concerns*. Washington, DC: Center for Health Care Strategies, Community Report No. 3, December.

[34] These amounts may vary from totals in official reports due to differences in methods used to compile records.

FIGURE 2: DISTRIBUTION OF FEE-FOR-SERVICE INPATIENT USERS BY TOTAL PAYMENTS AND THE MATCHING TREND IN CUMULATIVE PAYMENTS, ALL USERS, FY2009



Source: GW analysis of Medicaid data provided by DSHS

By Program Code

As shown in Table 4, approximately half of all fee-for-service payments for inpatient hospital services are for persons with a Medicaid program code of "Disabled." Only about one-third of users are in this category, however. Add the Disability Lifeline categories (GA-X and GA-U) and Blind categories to Disabled and the percentage of total payments jumps to 60 percent in FY2009.

Pregnant women are the next largest single group of fee-for-service users, accounting for nearly the same percentage of total users as the Disabled category, but only about 14 percent of total payments for inpatient services in FY2009. Payments for the users in the Children's program code spiked upward in FY2009. A small number of very high-cost cases contributed to this increase, as did a jump in the number of users and the rate increases discussed earlier.

TABLE 4: FEE-FOR-SERVICE PAYMENTS FOR HOSPITAL INPATIENT SERVICES, BY PROGRAM CODE, FY2008 AND FY2009

Program Code	FY2008		FY2009		
	Payments ($millions)	**Users***	**Payments** ($millions)	**Users***	**Payments per User**
Disabled	$267.7	12,518	$315.9	14,562	$21,695
Pregnant women	$74.7	12,973	$81.7	14,322	$5,705
Children's	$41.5	2,345	$61.5	2,825	$21,784
AFDC-R/TANF	$43.7	4,215	$49.7	4,828	$10,297
GA-X (Presumptive SSI)	$41.5	2,604	$47.9	3,020	$15,866
Aged	$19.6	1,239	$21.7	1,325	$16,348
Disability Lifeline (GAU)	$15.4	2,692	$17.6	3,269	$5,382
Foster care/adoption	$13.4	669	$15.3	717	$21,297
State-funded children	$5.2	379	$7.3	529	$13,867
Mental health ITA	$2.0	381	$3.4	564	$6,113
ADATSA	$1.7	402	$2.4	485	$4,968
Breast/cervical cancer	$1.3	119	$1.7	143	$11,770
CHIP	$0.9	65	$1.3	87	$14,859
Medically indigent	$0.6	204	$1.0	290	$3,279
Refugee	$0.4	35	$0.4	37	$11,870
Blind	$0.4	24	$0.4	34	$11,375
All program codes (total)	**$530.0**	**39,884**	**$629.3**	**45,725**	**$13,763**

Source: GW analysis using Medicaid data provided by DSHS

Note: Sorted by total payments in FY2009

* Unique users within each program code; individual users may have multiple inpatient visits. The numbers of users by program code will not sum to the total number across all program codes because some users had more than one program code during the year, and program codes with <10 users are excluded from the detail lines.

The profile of expenditures varies for each of these groups. Consider the top two categories in Table 4:

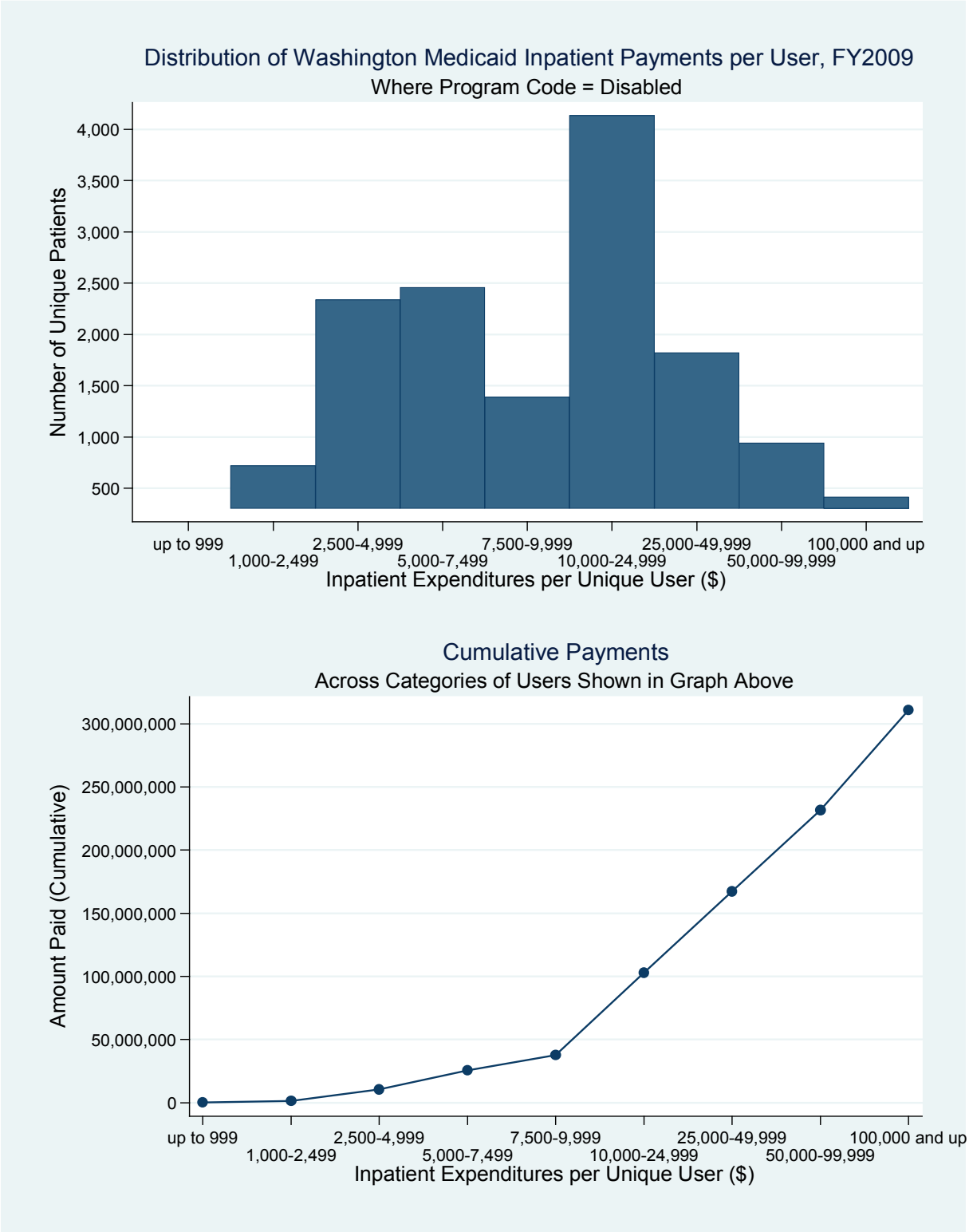
- Average (about $21,700) and median amounts (about $10,000) are substantially higher for inpatient users with a program code of "Disabled" than the figures for all fee-for-service inpatient users combined. About 1 out of every 10 inpatient hospital users with this program code had claims totaling more than $48,000 in payments during FY2009, and they were significant drivers of total spending for this group (Figure 3).

  Diagnoses among the highest-cost cases for people with a program code of "Disabled" in FY2009 included other diseases of lung, septicemia, heart failure, complications peculiar to certain specified procedures, diabetes mellitus, encounters for other and unspecified procedures and aftercare, pneumonia (organ unspecified), chronic bronchitis, care involving use of rehabilitation procedures, diseases of pancreas, other forms of ischemic heart disease and other cellulitis and abscess. These diagnoses reflect a wide range of critical acute care needs and chronic conditions which are prevalent among low-income persons with disabilities.

- For fee-for-service inpatient hospital users with a program code of "Pregnant," the average (about $5,700) and median (about $3,900) payment amounts are much lower than for all fee-for-service inpatient users. There are some very high-cost pregnant women, but less than 1 in 10 had total fee-for-service inpatient claims exceeding $8,500 in FY2009. The high-cost cases still contribute disproportionately to the overall fee-for-service spending on inpatient services for pregnant women (Figure 4).

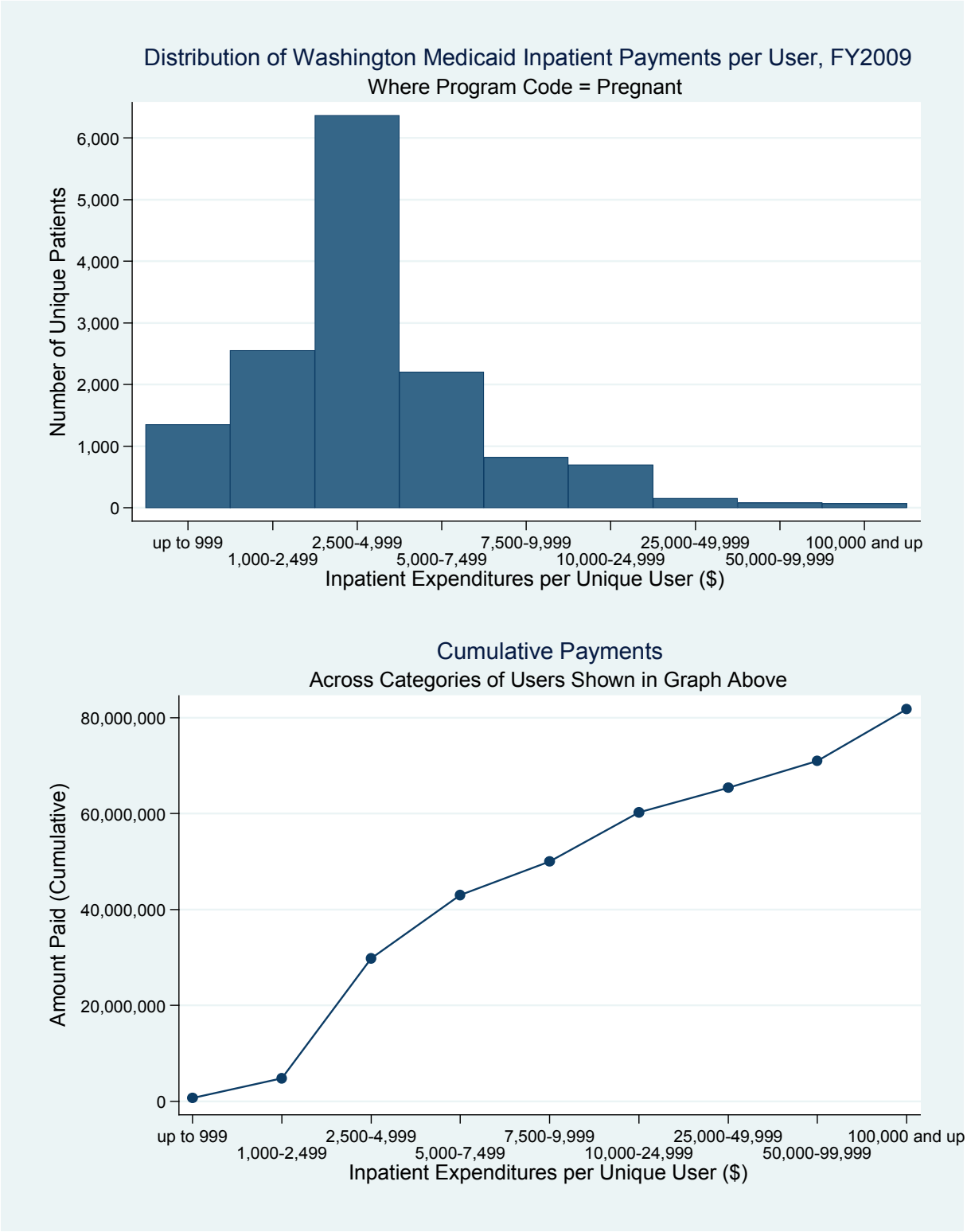
  Common diagnoses among the highest-cost pregnant women in fee-for-service in FY2009 included codes for single and twin liveborn infants, but also numerous complications mainly related to pregnancy or occurring mainly in the course of labor and delivery. These include: abnormality of organs and soft tissues of pelvis; early or threatened labor; hypertension complicating pregnancy, childbirth and the puerperium (the period after childbirth before the mother returns to a normal reproductive state); current conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth or the puerperium; problems associated with the amniotic cavity and membranes; indications for care or intervention related to labor and delivery not elsewhere classified; abnormality of forces of labor; and trauma to perineum and vulva during delivery.

FIGURE 3: DISTRIBUTION OF FEE-FOR-SERVICE INPATIENT USERS BY TOTAL PAYMENTS AND THE MATCHING TREND IN CUMULATIVE PAYMENTS, PROGRAM CODE = DISABLED, FY2009



Source: GW analysis of Medicaid data provided by DSHS

FIGURE 4: DISTRIBUTION OF FEE-FOR-SERVICE INPATIENT USERS BY TOTAL PAYMENTS AND THE MATCHING TREND IN CUMULATIVE PAYMENTS, PROGRAM CODE = PREGNANT, FY2009



Source: GW analysis of Medicaid data provided by DSHS

By Diagnosis

The previous section touched on leading diagnoses for persons with disabilities and pregnant women using inpatient services on a fee-for-service basis. Table 5 shows the top 25 categories of diagnoses across all fee-for-service inpatient users, ranked by total payments, in FY2009. The 25 codes shown accounted for nearly half (44%) of total fee-for-service inpatient payments in FY2009.

TABLE 5: PAYMENTS FOR FEE-FOR-SERVICE INPATIENT SERVICES IN FY2009, BY DIAGNOSIS

Code[A]	Description	Payments ($millions)	Users[B]	Payments per User
V30	Single liveborn	$48.6	15,518	$3,135
518	Other diseases of lung	$24.5	799	$30,606
038	Septicemia	$24.4	1,015	$24,034
296	Episodic mood disorders	$14.8	1,921	$7,722
996	Complications peculiar to certain specified procedures	$13.5	690	$19,532
746	Other congenital anomalies of heart	$10.4	48	$216,727
428	Heart failure	$8.8	579	$15,120
250	Diabetes mellitus	$8.7	790	$10,990
V31	Twin birth mate liveborn	$8.7	225	$38,564
486	Pneumonia organism unspecified	$8.5	1,036	$8,202
682	Other cellulitis and abscess	$8.4	1,199	$7,030
648	Other current conditions in the mother classifiable elsewhere but complicating pregnancy childbirth or the puerperium	$8.4	1,707	$4,937
295	Schizophrenic disorders	$8.2	625	$13,059
414	Other forms of chronic ischemic heart disease	$8.0	423	$19,016
V57	Care involving use of rehabilitation procedures	$8.0	386	$20,756
654	Abnormality of organs and soft tissues of pelvis	$7.5	1,794	$4,187
410	Acute myocardial infarction	$7.5	385	$19,399
664	Trauma to perineum and vulva during delivery	$7.4	2,879	$2,584
V58	Encounter for other and unspecified procedures & aftercare	$6.7	260	$25,729
770	Other respiratory conditions of fetus and newborn	$6.6	114	$57,593
577	Diseases of pancreas	$6.4	518	$12,433
715	Osteoarthrosis and allied disorders	$6.3	464	$13,592
745	Bulbus cordis anomalies & anomalies of cardiac septal closure	$5.9	68	$87,337
491	Chronic bronchitis	$5.8	642	$9,082
998	Other complications of procedures not elsewhere classified	$5.3	420	$12,690
Top 25		$277.4		
All codes		**$629.3**	**45,725**	**$13,763**

Source: GW analysis of Medicaid data provided by DSHS

A) This analysis uses only the first three digits of the ICD-9 diagnosis codes reported on the Medicaid claims data provided to GW by DSHS. The codes represent the primary diagnosis, which is typically the main condition treated or the most intense care provided. The full five-digit codes reported on the claims provide more specificity, but the first three digits group similar diagnoses into general categories.

B) Unique users; individual users may have multiple inpatient visits.

The high percentage of fee-for-service inpatient hospital users who are pregnant women and newborns is evident in the leading diagnoses. Single live birth, twin births and several complications of pregnancy and childbirth are on this list. These diagnoses reflect Medicaid's role as a primary payer for childbirth in Washington State[35], and may also indicate that women with adverse birth outcomes and complications are more likely to remain in fee-for-service. Given that pregnant women are in both fee-for-service and managed care, a further examination of costs in managed care may be warranted. In addition, the state would likely benefit from an examination of Neo Natal Intensive Care Unit (NICU) costs to Medicaid. GW was unable to gather and report those data in time for this report. However, DSHS officials noted that elective Cesarean section and less than 39 week deliveries drive NICU admissions and have proposed a number of initiatives to decrease elective Cesarean sections and elective early deliveries, as discussed in the "Options" section of this report.

Other leading diagnoses among fee-for-service inpatient users include acute illness and injuries, chronic physical conditions such as diabetes and heart disease, and mental/behavioral health conditions such as episodic mood disorders and schizophrenic disorders. These diagnoses highlight the diversity of health care needs in the fee-for-service Medicaid population. Medicaid patients include low-income families and children, foster children, seniors and persons with disabilities with low incomes, significant numbers of individuals with alcohol and/or substance abuse issues (active or in the past), institutionalized or community-dwelling long-term care recipients, and more. Every one of these groups has a different set of physical and behavioral health care needs and patterns of use.

A third set of leading diagnoses among fee-for-service users reflect challenges inherent in inpatient care, including complications of medical procedures. For example, septicemia (sepsis) is a severe form of bacterial infection usually acquired in a hospital.[36] Surgical sepsis is a potentially preventable cause of morbidity (illness/injury) and mortality (death). Incidences of sepsis and septic shock greatly exceed those of pulmonary embolism and myocardial infarction in general surgery, despite a recent focus on prevention of all three of these complications in the surgical community.[37] Risk is higher for certain groups with conditions that limit their ability to fight serious infections, including:

- Newborns;
- People over 35;
- Pregnant women;
- People with certain chronic disorders such as diabetes or cirrhosis; and
- People with weakened immune systems—due to use of drugs that suppress the immune system (immunosuppressants, such as chemotherapy drugs) or corticosteroids, or due to certain disorders (such as cancer, AIDS, and immune disorders).[36]

[35] Washington State Senate Committee Services (2011). *Washington's state-funded medical programs for low-income people.* Presentation of Tim Yowell before the Washington Senate Ways & Means Committee. January 24.
[36] Young, L. S. (2008). *Sepsis and septic shock.* Retrieved 03/18, 2011, from http://www.merckmanuals.com/home/sec17/ch191/ch191c.html#sec17-ch191-ch191c-391
[37] Moore, L. J., Moore, F. A., Todd, S. R., Jones, S. L., Turner, K. L., & Bass, B. L. (2010). Sepsis in general surgery: The 2005-2007 national surgical quality improvement program perspective. *Archives of Surgery, 145*(7), 695-700. doi:10.1001/archsurg.2010.107.

In other words, most of the fee-for-service Medicaid population has elevated risk for sepsis. This life-threatening condition typically requires an extended stay in an intensive care unit (ICU), and mortality rates remain high despite advances in awareness and treatment. It is one of the top three diagnoses (ranked by total payments) in both years GW examined, reflecting this level of care and the elevated risk. Importantly, sepsis may have long-term health consequences for surviving patients.[38]

Lastly, several diagnoses listed in Table 5 could be ambulatory sensitive conditions and thus represent potentially avoidable hospitalizations. Examples include chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes and pneumonia.

Multiple Inpatient Stays/Readmissions

Using Medicaid fee-for-service claims data provided by DSHS, GW identified patients with multiple inpatient stays by treating all inpatient claims for a single patient with contiguous service dates as one inpatient stay, even if the billing provider number changes. A shortcoming of this method is that it will count only one stay if a hospital discharges a patient and that patient is readmitted to the same hospital or a different hospital the same day or next day. It also will code transfers to or from other hospitals as a single stay, which may not always be appropriate.

Based on GW's analysis, 8 out of 10 fee-for-service inpatient hospital users in FY2008 and FY2009 had one stay, and more than 9 out of 10 had two or fewer stays. Less than one percent of patients had five or more stays. While few in number, patients with multiple stays account for a disproportionate share of fee-for-service payments for inpatient services (Figure 5). Users with program codes of Aged, Disabled, Disability Lifeline (GAU) or GA-X (Presumptive SSI) were more likely to have multiple fee-for-service admissions (data not shown).

Federal policymakers have targeted inpatient readmissions—generally defined as admissions within 30 days of a previous discharge for the same or similar condition—as a quality-of-care measure and as a cost containment opportunity. One recent study found that nearly 1 in 5 Medicare beneficiaries discharged from a hospital were readmitted within 30 days, based on 2003-2004 Medicare claims data.[39] The Medicare Payment Advisory Commission (MedPAC) found that many readmissions may be preventable,[40] and recommended reduced Medicare payments for readmissions.[41] The Affordable Care Act established financial penalties in Medicare, to be implemented in October 2012, for hospitals with above-average risk-adjusted rates of preventable readmissions for three conditions to be selected by the Secretary of the U.S. Department of Health and Human Services. The law expands the penalties to include readmissions for additional conditions, also to be determined by the Secretary, in later years.[42] Whatcom County, WA, is one of 14 locations nationwide participating in a federal pilot project aimed at

[38] Angus, D. C. (2010). The lingering consequences of sepsis. *JAMA: The Journal of the American Medical Association, 304*(16), 1833-1834. doi:10.1001/jama.2010.1546

[39] Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine, 360*(14), 1418-1428. Retrieved from http://dx.doi.org/10.1056/NEJMsa0803563

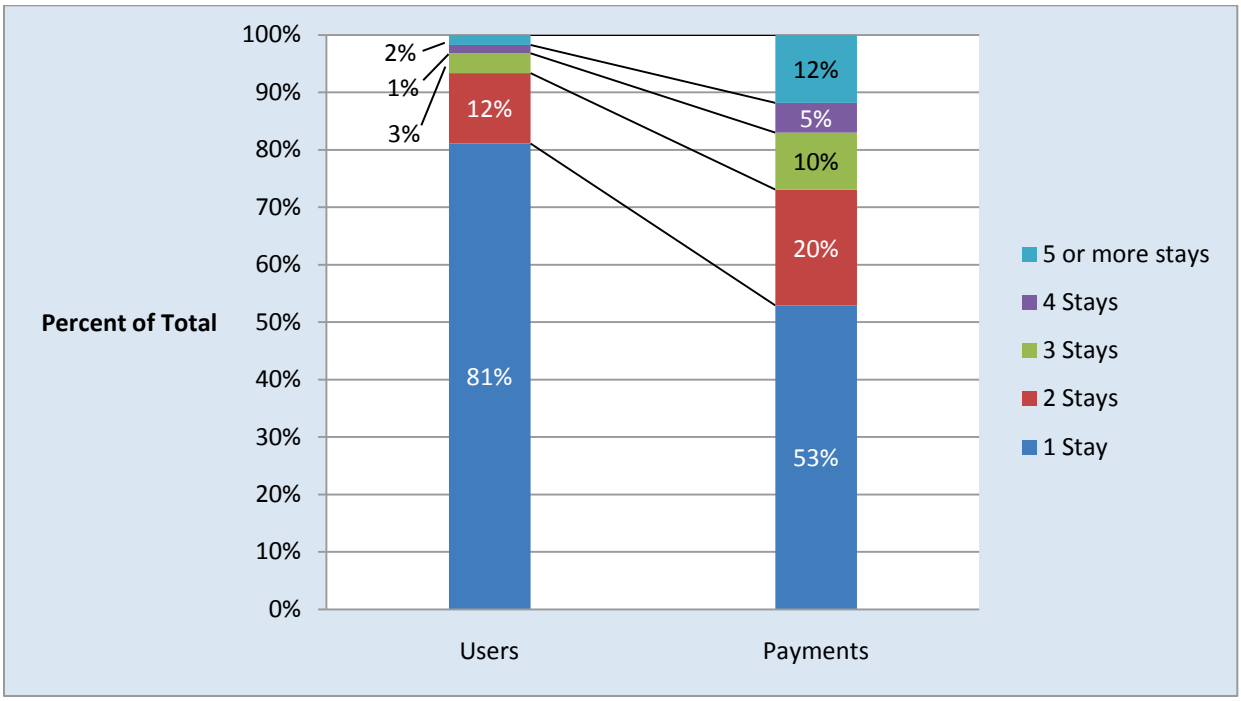
[40] Medicare Payment Advisory Commission. (June 2007). *Payment policy for inpatient readmissions.* (Report to the Congress: Promoting Greater Efficiency in Medicare) Washington, DC: Medicare Payment Advisory Commission.

[41] Medicare Payment Advisory Commission. (June 2008). *A path to bundled payment around a hospitalization.* (Report to Congress: Reforming the Delivery System) Washington, DC: Medicare Payment Advisory Commission.

[42] HR 3590, Title III Subtitle A, Sec. 3025

reducing readmissions and promoting smooth transitions between settings of care. These federal actions could produce some savings for Washington Medicaid, to the extent that they could potentially reduce readmissions among dually-eligible beneficiaries.

FIGURE 5: DISTRIBUTIONS OF FEE-FOR-SERVICE USERS OF AND PAYMENTS FOR INPATIENT HOSPITAL SERVICES, BY NUMBER OF STAYS PER USER, FY2009



Source: GW analysis of Medicaid data provided by DSHS

Washington has long had processes in place to review claims for readmissions within 7 days following a prior hospital discharge. These reviews determine whether the readmission could have been avoidable, and may deny payment for the second admission. Savings are modest but not insignificant; officials estimated more than $3 million in denied claims/recoveries annually. Expanding the program to review readmissions over a longer time period (e.g. 14 or 30 days) could potentially provide more savings but would require additional staffing. Officials also expressed concern that a 30-day window could lead to more appeals by providers and, consequently, higher administrative costs. This analysis does not attempt to measure the prevalence of 7-day, 14-day or 30-day readmissions in Washington's fee-for-service Medicaid program.

Inpatient Hospital Service Users in Washington and Other States

Few resources are available that allow researchers or state officials to compare service use or program expenditures among different state Medicaid programs. Medicaid Analytic eXtract (MAX) data from the Centers for Medicare & Medicaid Services (CMS) are the most complete data available across states but there is a lag of a few years before they are released. They are also a product of the Medicaid Statistical Information System (MSIS) and therefore subject to numerous limitations that impinge on comparisons

among states, as discussed in GW's first report.[43] These concerns, along with the timeline and resources available for this analysis, prevented us from using MAX data to compare Washington and other states. Such an analysis might be worthwhile as a follow up, if officials remain interested in cross-state analyses.

For this report, GW turned to State Inpatient Databases (SID) compiled by the Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). The SIDs include inpatient hospital discharge data for all or mostly all payers in each state, including Medicaid. The information available from the SIDs includes basic demographics for patients (e.g., age, gender, and race/ethnicity), primary diagnosis codes, secondary and other diagnoses, and charges reported on the discharge records. The unit of analysis is the discharge record, not individual patients.

GW conducted a brief analysis of calendar year 2007 data from Washington and five other states: California, Massachusetts, New Jersey, Oregon and Wisconsin. These five states were the most appropriate comparisons out of the 26 states for which GW could obtain SID files, based on geographic proximity or general reputation as states with comprehensive Medicaid programs. GW limited its analysis to discharges listing Medicaid as a payer, which includes patients from Medicaid managed care organizations (MCOs) and traditional Medicaid fee-for-service programs. As noted previously, about 57 percent of Washington Medicaid enrollees are in comprehensive managed care plans. This is a key difference between this analysis and the rest of the report, as the focus of virtually all other tables in this report is the fee-for-service population.

Among all inpatient hospital discharges in 2007, GW observed only minor differences in basic patient demographics and the most common primary diagnosis codes between discharges paid for by Medicaid in Washington and the five comparison states. The results of this analysis are in the Appendix. These results suggest that, at least by this limited set of measures, the Medicaid population using inpatient hospital services in Washington is not substantively different from other states.

[43] George Washington University Department of Health Policy (2011), op. cit.

Summary of Hospital Outpatient Use and Payments

Medicaid fee-for-service data provided to GW by DSHS included hospital outpatient service claims totaling $204 million for FY2008 and $245 million for FY2009. Based on unique patient identifiers (de-identified), there were approximately 182,200 unique patients in FY2008 and 210,800 unique patients in FY2009 who used outpatient services. These payment and utilization levels translate to an average (mean) annual cost of about $1,140 per user over the two-year period (Table 6).[44]

TABLE 6: SUMMARY OF FEE-FOR-SERVICE HOSPITAL OUTPATIENT USE AND PAYMENTS

Measure	FY2008	FY2009
Total amount paid	$204 million	$245 million
Unique users	182,209	210,823
Average (mean) per user	$1,118	$1,159
Median per user*	$337	$335

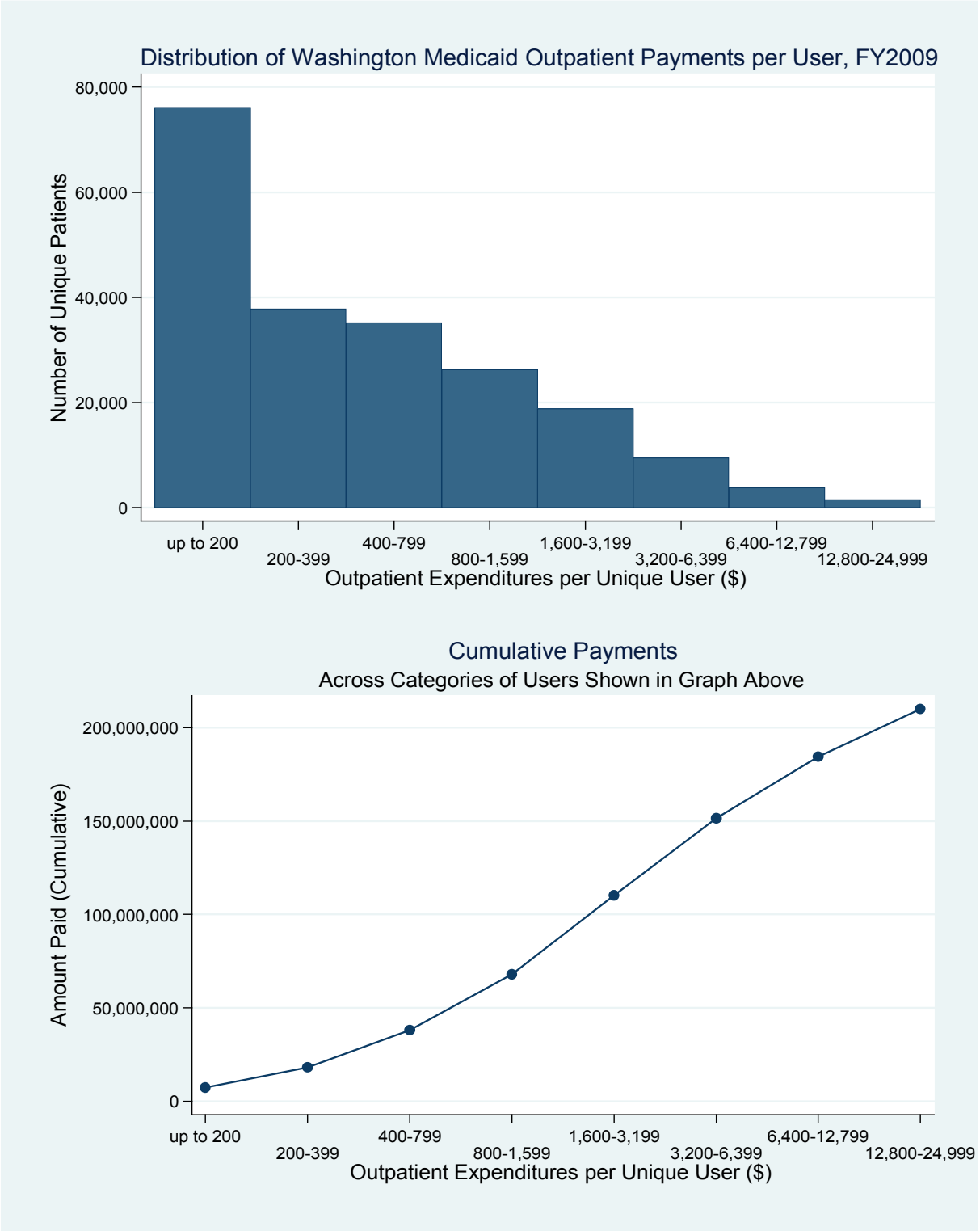
Source: GW analysis using Medicaid data provided by DSHS

* The median is the mid-point of the distribution; half of all users have total payments that are higher than the median, and half of all users have total payments that are below the median.

As with inpatient services, median total payments for outpatient service users are considerably less than the average total payment per user. Half of all outpatient users required less than $335 in payments for outpatient services in FY2009 and most totaled less than $800. However, as with inpatient care, smaller numbers of high-cost users contribute disproportionately to total costs (Figure 6).

[44] These amounts may vary from totals in official reports due to differences in methods used to compile records.

FIGURE 6: DISTRIBUTION OF FEE-FOR-SERVICE OUTPATIENT USERS BY TOTAL PAYMENTS AND THE MATCHING TREND IN CUMULATIVE PAYMENTS, ALL OUTPATIENT USERS, FY2009



Source: GW analysis of Medicaid data provided by DSHS

By Program Code

The outpatient data in this report reflect claims for fee-for-service users only; GW did not have access to data on outpatient encounters for patients in managed care plans. Most fee-for-service users are SSI recipients, dual eligibles and Medicaid only individuals aged 65 and older and younger persons with disabilities, as well as some pregnant women. Families and children are primarily in managed care.

Persons with a program code of "Disabled," accounted for nearly half of all fee-for-service payments for outpatient services in FY2008 and FY2009 (Table 7). They were also the largest group of unique users, but only accounted for about 30 percent of all users. This difference reflects the higher average annual costs for persons coded as disabled.

The next highest group in terms of total fee-for-service payments for outpatient services is parents and children in the AFDC-R/TANF category, at roughly 10% of total payments, despite the fact that most people with this code are in managed care. Disability Lifeline categories (GAU and GA-X/Expedited) and aged program codes round out the top five fee-for-service categories. Managed care for Disability Lifeline excludes outpatient services, and aged beneficiaries have high relative costs per user.

TABLE 7: PAYMENTS FOR FEE-FOR-SERVICE HOSPITAL OUTPATIENT SERVICES, BY PROGRAM CODE, FY2008 AND FY2009

Program Code	FY 2008		FY 2009		
	Payments ($millions)	**Users***	**Payments** ($millions)	**Users***	**Payments per User**
Disabled	$93.5	54,225	$115.4	60,474	$1,909
AFDC-R/TANF	$19.4	36,825	$23.6	42,198	$558
Disability Lifeline (GAU)	$17.1	15,815	$22.3	20,303	$1,099
GA-X (Presumptive SSI)	$18.4	12,790	$21.2	14,517	$1,457
Aged	$20.3	6,133	$20.4	6,989	$2,923
Pregnant women	$13.4	25,396	$14.9	28,885	$515
Children	$8.3	21,327	$10.3	26,513	$390
State-funded children	$3.0	6,033	$4.2	8,656	$487
Foster care/adoption	$3.5	6,481	$4.2	7,374	$563
Breast/cervical cancer	$3.1	606	$3.8	741	$5,107
ADATSA	$2.9	4,528	$3.1	4,922	$626
CHIP	$0.3	738	$0.5	1,193	$399
Refugee	$0.2	425	$0.3	580	$486
Blind	$0.2	163	$0.3	203	$1,287
Take charge family planning	$0.1	84	$0.2	111	$1,659
All program codes (total)	**$203.8**	**182,208**	**$244.5**	**210,823**	**$1,160**

Source: GW analysis using Medicaid data provided by DSHS

* Unique users within each program code; individual users may have multiple outpatient visits. The numbers of users by program code will not sum to the total number across all program codes because some users had more than one program code during the year, and program codes with <10 users are excluded from the detail lines.

By Diagnosis Code

The 25 leading categories of diagnoses for fee-for-service outpatient hospital services, ranked by total payments, encompass a wide range of conditions (Table 8). These categories, which accounted for 40 percent of all outpatient payments in FY2009, highlight the diversity of fee-for-service enrollees. There are relatively high-cost conditions afflicting few users such as chronic kidney disease, chronic ischemic heart disease, and cancer (malignant neoplasm). Other diagnoses reflect recurrent care associated with major illnesses or chronic conditions. For example, other and unspecified procedures and aftercare (V58) include radiotherapy, chemotherapy and immunotherapy, aftercare following surgery, and fitting or adjustment of catheters. Still other diagnoses are relatively low-cost, episodic ailments or injuries affecting larger numbers of users, who may seek care for treatment or assessment of symptoms.

TABLE 8: PAYMENTS FOR FEE-FOR-SERVICE OUTPATIENT SERVICES IN FY2009, BY DIAGNOSIS

Code[A]	Description	Payments ($millions)	Users[B]	Payments per User
585	Chronic kidney disease (ckd)	$12.3	1,217	$10,109
V58	Encounter for other and unspecified procedures & aftercare	$12.3	8,668	$1,416
789	Other symptoms involving abdomen and pelvis	$10.1	16,219	$623
786	Symptoms involving respiratory system & other chest symptoms	$8.5	15,462	$550
780	General symptoms	$5.4	14,657	$368
521	Diseases of hard tissues of teeth	$4.5	6,285	$709
724	Other and unspecified disorders of back	$3.5	10,838	$321
174	Malignant neoplasm of female breast	$3.2	938	$3,457
784	Symptoms involving head and neck	$3.1	7,941	$386
799	Other ill-defined, unknown causes of morbidity & mortality	$2.9	592	$4,951
787	Symptoms involving digestive system	$2.6	8,225	$314
719	Other and unspecified disorders of joint	$2.6	11,133	$230
162	Malignant neoplasm of trachea bronchus and lung	$2.4	536	$4,483
682	Other cellulitis and abscess	$2.3	7,117	$326
574	Cholelithiasis (gallstones)	$2.2	1,173	$1,915
V57	Care involving use of rehabilitation procedures	$2.2	5,434	$401
250	Diabetes mellitus	$2.1	5,976	$356
648	Other current conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth or the puerperium	$2.1	6,809	$305
996	Complications peculiar to certain specified procedures	$2.1	1,349	$1,526
V22	Normal pregnancy	$2.0	9,687	$211
290	Dementias	$2.0	254	$7,745
414	Other forms of chronic ischemic heart disease	$2.0	975	$2,015
599	Other disorders of urethra and urinary tract	$1.8	6,115	$287
847	Sprains and strains of other and unspecified parts of back	$1.7	6,436	$264
338	Pain, not elsewhere classified	$1.6	5,984	$265
Top 25		**$97.3**		
All codes		**$244.5**	**210,823**	**$10,109**

Source: GW analysis of Medicaid data provided by DSHS [table notes on next page]

A) This analysis uses only the first three digits of the ICD-9 diagnosis codes reported on the Medicaid claims data provided to GW by DSHS. The codes represent the primary diagnosis, which is typically the main condition treated or the most intense care provided. The full five-digit codes reported on the claims provide more specificity, but the first three digits group similar diagnoses into general categories.
B) Unique users; individual users may have multiple outpatient visits.

Who are the Primary Users of Outpatient Care?

Due to variations in provider billing practices, the abbreviated fee-for-service claims data available to GW for this project were not well-suited to profiling the most frequent users of outpatient services. However, using total payments for outpatient services as a proxy for frequent use sheds some light on the groups and diagnoses/conditions most likely to result in frequent outpatient use. GW identified the top 10 percent of outpatient users, ranked by total payments, and separately studied the diagnosis codes present on claims for this population and the program codes listed on those claims. The analysis included more than 1.4 million records (FY2009).

Not surprisingly based on the results shown to this point, the most common program code on claims for high-cost fee-for-service outpatient users in 2009 was “Disabled.” The next two codes are Disability Lifeline (GA-X/Expedited (Presumptive SSI) and GAU). Most non-disabled enrollees won’t show up among the highest fee-for-service users since they are in MCOs.

Similarly, the most common diagnosis codes among the top 10 percent of outpatient users, ranked by total payments, coincide with the leading codes among all users shown in Table 8. There are only minor differences in the order of the leading diagnoses, particularly among the first ten codes. This analysis underscores the earlier findings that these populations and diagnoses are primary drivers of costs in Washington’s fee-for-service Medicaid program.

Relatively few pregnant women end up in the top 10 percent of all fee-for-service outpatient users ranked by total payments. However, given the frequency/cost of pregnancy, birth, and post-partum complications observed among inpatient users, GW examined the most common diagnoses for the top 10 percent of pregnant women who use fee-for-service outpatient services (ranked by total payments). Notable among the findings is that “other current conditions in the mother” (code 648) turned up most often on claims for pregnant women with the highest outpatient costs. These conditions include diabetes and abnormal blood sugar tolerance, thyroid dysfunction, anemia, drug dependence, mental disorders, congenital and other cardiovascular disorders, and bone and joint disorders.

EMERGENCY DEPARTMENT CARE

Overuse of emergency departments (EDs) by Medicaid enrollees is a national issue, not just an issue for Washington. Research shows that Medicaid enrollees are significantly more likely to use EDs, as are people with low incomes and people in poor physical or mental health.[45,46] Frequent ED users have many chronic conditions and are more than twice as likely to be a Medicaid enrollee as the general population.[47] One of the reasons for instituting managed care programs is to minimize the use of EDs for primary care reasons. However, states have found that even with a managed care program, members still go to emergency departments for non-emergent care. Research also suggests that having a usual source of care is not associated with a lower likelihood of ED use.[48]

ED Use and Payments

An analysis provided to GW by DSHS indicated that in FY2009, Washington spent $106 million on ED services for 154,400 users in the fee-for-service program. The DSHS analysis focused on the population that could be affected by benefit reduction initiatives, so these figures exclude Alien Emergency Medical (AEM) users because the ED is the only way they can access federally-funded emergency services under Medicaid, and also users presenting in crisis for mental health emergency room care, including detoxification. Of the 154,400 users, more than 9,000 (about 6%) had four or more emergency room visits that appeared to be for non-emergent conditions; nearly 900 had 12 or more visits. As defined by DSHS, these non-emergent conditions include (but are not limited to) diagnoses such as ear infections, upper respiratory infections, skin disorders such as sunburn and dermatitis, visits for lab and diagnostics or preoperative testing, headache or migraine, and joint or back pain.

DSHS estimated the non-emergent status of visits using a model based on a program currently used by New York Medicaid. These individuals utilize different hospitals throughout the state, so the problem does not appear to be confined to particular areas.

State Efforts to Reduce ED Use

Washington officials previously recognized ED use as an area of concern and DSHS has been addressing it through multiple initiatives, discussed in more detail in GW's earlier report.[49] These include:

- Pilot projects with four Federally Qualified Health Centers (FQHCs) to expand primary care services and offer extended hours. An evaluation of this project will be released in 2011.

[45] Weber, E.,J., Showstack, J.,A., Hunt, K.,A., Colby, D.,C., & Callaham, M.,L. (2005). Does lack of a usual source of care or health insurance increase the likelihood of an emergency department visit? Results of a population-based study. *Annals of Emergency Medicine, 45*(1), 4-12. doi:10.1016/j.annemergmed.2004.06.023

[46] Hunt, K.,A., Weber, E.,J., Showstack, J.,A., Colby, D.,C., & Callaham, M.,L. (2006). Characteristics of frequent users of emergency departments. *Annals of Emergency Medicine, 48*(1), 191-200. doi:10.1016/j.annemergmed.2005.12.030

[47] Peppe, E. M., Mays, J. W., Chang, H. C., Becker, E., & DiJulio, B. (October 2007). *Characteristics of frequent emergency department users.* Menlo Park, CA: The Henry J. Kaiser Family Foundation.

[48] Weber et al (2005), op. cit.

[49] George Washington University Department of Health Policy (2011), op. cit.

- Expand its lock-in program for chronic abusers in fee-for-service to the MCOs.
- Hold back one percent from the MCOs as an incentive to control ED use among their enrollees.
- Implement the hospital assessment legislation which allows non-critical access hospitals to receive a one percent inpatient rate increase on July 1, 2012, if they meet the threshold for defined quality measures. These measures include plans to reduce preventable ED visits.
- The state's Chronic Care Management Programs are also intended to reduce ED use for high-risk populations.

These multiple approaches each seem appropriate as methods to curb ED use, although the variation in approaches also suggests some uncertainty about what actually works in practice. Some of these initiatives are new or just being rolled out, and they need to be monitored to assess whether they provide successful results.

Studies of pediatric ED use illustrate the challenges in changing patients' behaviors. A study of pediatric emergency room use among an urban Medicaid population found that caregivers chose the ED because of short wait times; nearly 60 percent of caregivers ranked wait time more important than seeing the same doctor every time (37.6%).[50] Another study of parents' decisions to seek non-urgent ED care for their children found that neither parents nor primary care physicians viewed non-urgent ED visits as a significant-enough problem to warrant changes in physician practices or parent behavior.[51]

[50] Moon, T. D., Laurens, M. B., Weimer, S. M., & Levy, J. A. (2005). Nonemergent emergency room utilization for an inner-city pediatric population. *Pediatric Emergency Care, 21*(6), 363-366.

[51] Brousseau, D. C., Nimmer, M. R., Yunk, N. L., Nattinger, A. B., & Greer, A. (2011). Nonurgent emergency-department care: Analysis of parent and primary physician perspectives. *Pediatrics, 127*(2), e375-381. doi:10.1542/peds.2010-1723

V. CARE MANAGEMENT FOR HIGH-RISK POPULATIONS

The findings presented in earlier sections of this report highlight opportunities for improved care management in Washington's fee-for-service Medicaid program. They also underscore the challenges, given the diversity of Medicaid patients, the complex variety of medical and behavioral health conditions presented by these individuals, and the generally higher prevalence of risk factors and established patterns of inefficient healthcare utilization.

Most families and children and roughly 40 percent of pregnant women are enrolled in MCOs. A small number of individuals aged 65 and older and persons with disabilities are in managed care under the Washington Medicaid Integration Project (WMIP) pilot. Most Disability Lifeline enrollees are also in managed care, but this plan excludes hospital inpatient and outpatient services and some other services which remain the state's responsibility in fee-for-service.

SERVICE USE AND EXPENDITURES

Previous sections of this report highlight certain groups of enrollees with high levels of inpatient and outpatient use and payments, and the diagnoses contributing most to total payments in these areas. Table 9 shows the average payments per user across various eligible groups and types of services based on data from the fee-for-service portion of Washington's Medicaid program in FY2009. GW classified users into eligible groups and payments into service types, based on coding provided in those data. The average payments for each combination of program code and type of service include only people using each type of service. In other words, they reflect average costs per user within each service. They are not per capita amounts for all enrollees with that program code, and they should not be added across service types. These figures illustrate which combinations of individuals and services may be more likely to provide opportunities for savings.

TABLE 9: AVERAGE FEE-FOR-SERVICE PAYMENTS PER USER BY PROGRAM CODE AND SERVICE CATEGORY, FY2009

Program Code	Type of Service						
	Drugs	Inpatient	Managed Care	Medicare	Nursing Home	Outpatient	Other
Aged	$483	$16,434	$1,373	$530	$27,071	$2,961	$887
Disabled	$2,137	$18,698	$668	$519	$23,136	$1,703	$1,717
Pregnant Women	$111	$5,738	$1,234	$461	$4,321	$522	$2,033
Families & Children	$297	$15,209	$1,136	$467	$8,362	$504	$595
Other	$260	$8,245	$1,081	$682	n/a	$779	$420

Source: GW analysis of Medicaid data provided by DSHS

Notes: "Other Providers" include physicians and other licensed health care providers, dental, medical vendors, and early and periodic screening, diagnosis and treatment (EPSDT) services. "Aged" includes program codes for Aged and Institutional Aged. "Disabled" includes program codes for Blind, Disabled, and Disability Lifeline (GAU and GA-X/Expedited (Presumptive SSI)). "Families & Children" includes program codes for AFDC-R/TANF, Foster Care/Adoption, and Children's. "Other" includes program codes for Family Planning, Breast/Cervical Cancer, Medically Indigent, Mental Health ITA, Refugee, ADATSA, and State-funded Children.

STATE EFFORTS TO IMPROVE CARE MANAGEMENT

Washington has used a "unique… adaptable 'learn as you go' approach to designing, testing, evaluating and refining multiple strategies to improve the quality and cost-effectiveness of care" for high-risk populations.[52] As discussed in GW's Phase One Report, the state has tried several approaches including:

- The Washington Disease Management Program (ended in 2006)
- Washington Medicaid Integration Partnership (ongoing)
- Three chronic care management programs, including:
  - ADSA Chronic Care Management Project
  - AmeriChoice Washington Care Management Project
  - King County Care Partners Chronic Care Management Project
- A lock-in program for certain patients who abused drug, hospital or emergency department services in the past;
- A narcotic review program focusing on very high use cases;
- An extensive second opinion program and mental health consultation services targeting high use of mental health services by youths and high use of mental health drugs;
- Efforts to address medication non-adherence for high-cost mental health clients;
- Notifications sent to providers to help effect changes in outlier prescribing patterns (part of the state's "Generics First" program legislated in 2009); and
- A patient-centered medical home demonstration.

As also described in the Phase One Report, the state has experience with more comprehensive managed care programs for aged, blind and disabled populations. The state began implementation of managed care for these populations in October 1995, with a risk-sharing primary care case management (PCCM) model in Clark County. The financial results were promising. In 1997, Washington began a mandatory Medicaid managed care program for SSI beneficiaries in the Spokane metro area, in the eastern part of the state. Although enrollment grew rapidly, the program ended in 1998 when the MCOs refused to accept the rates offered by the state. A subsequent analysis of the experience conducted by the Center for Health Care Strategies concluded that the state probably implemented the program too quickly given the inherent complexities involved, that it should have used risk adjustments in setting rates, and that it did not clarify the role of care coordinators to focus solely on the care of the beneficiaries.[53]

The state is currently planning to enroll more persons with disabilities and other high-risk, high-use populations in MCOs. The proposal calls for procurement in 2011, with enrollment to begin in 2012. Workgroups at the Medicaid Purchasing Authority are currently working through design and implementation issues.

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[52] Center for Health Care Strategies. (2008). *Washington State Medicaid: An evolution in care delivery*. Hamilton, NJ: Center for Health Care Strategies. Retrieved from http://www.chcs.org/publications3960/publications_show.htm?doc_id=759948

[53] Verdier, J. et al. (1998). *Washington State's experience in extending Medicaid managed care to the SSI population: A retrospective analysis*. Hamilton, NJ: Center for Health Care Strategies.

POTENTIAL SAVINGS

In Washington and most other states, a majority of pregnant women, parents and children in Medicaid are in managed care plans. Given the breadth of state experiences with these populations and their generally lower health needs and costs compared to persons with disabilities and seniors, managed care systems are easier to develop and implement for these populations. There has been considerable interest in enrolling higher-risk populations in managed care, particularly because the cost of caring for them is much greater, whether measured per enrollee or as a proportion of overall Medicaid program expenditures. States' objectives in enrolling high-risk, high-risk populations are two-fold: to improve the delivery of services to a population that generally use services at a high rate; and to achieve cost savings by reducing the amount of unnecessary or duplicate services provided to the population.

Over time, numerous state Medicaid agencies have enrolled persons with disabilities and other high-risk populations into managed care programs. Studies of such programs show mixed results. Assumptions that managed care will produce cost savings for high-risk populations are based on the premise that these are high-cost populations with complex health care needs, largely served by fee-for-service plans with little coordination of care. Therefore, coordinated care provided by a MCO is expected to result in a more appropriate level of services and that efficiencies will result in savings.

A potential flaw in this argument is that it assumes that high-risk populations have full access to services in the fee-for-service program, if not excessive levels of service use. If, however, high-risk populations do not use *enough* services or have limited access to services under Medicaid, greater coordination of care could lead to higher costs, not lower costs, at least at first.

The Texas STAR+PLUS program provides integrated primary, acute and long-term care services to SSI and SSI-related populations including the dually eligible. Originally implemented in Harris County (Houston) the program was later rolled out to several urban centers across Texas. Initial evaluations of STAR+PLUS showed that the program achieved significant cost savings over time. Combined savings in the first two years of the program equaled $4.11 per member per month (PMPM).[54] In the third and fourth years, savings equaled $91.67 PMPM.[55] This later number represents an almost 17 percent reduction in state Medicaid costs as compared to projected fee-for-service costs for the same population. In terms of impact on service use, during the initial period measured, the primary savings came from reduced emergency room visits, while inpatient discharge rates and average length of stay was the same as the fee-for-service population. However, during the second time period, reductions in the number of inpatient discharges and average length of stay were also achieved.

A study by the Center for Health Care Strategies looked at the impact of the Oklahoma managed care program, Soonercare, on elders and persons with disabilities in 2000. The study compared the costs of aged, blind and disabled enrollees in the fee-for-service program and then after enrollment in capitated MCOs. The population studied resided in urban settings. The average PMPM decreased by 15 percent

[54] Texas A&M Public Policy Research Institute. (1999). *STAR+PLUS Medicaid managed care waiver study: An independent assessment of access, quality, and cost-effectiveness*. College Station, TX: Texas A&M Public Policy Institute.

[55] Texas A&M Public Policy Research Institute (2002). *Medicaid managed care waiver study: an independent assessment of access, quality, and cost-effectiveness of the STAR+PLUS program.* College Station, TX: Texas A&M Public Policy Institute.

and the overall cost of the program decreased by four percent relative to fee-for-service costs. Members believed they had a fuller range of services under the managed care program and that care coordination had improved compared to fee-for-service.[56] Later analysis found that, compared to national averages and 19 other states with various kinds of managed care and fee-for-service delivery systems, Oklahoma's Medicaid program has had relatively low costs on a per-member basis since the inception of the SoonerCare managed care program.[57]

A more recent study, however, reaches the conclusion that there are no cost savings when comparing program cost for aged, blind and disabled populations enrolled in managed care to those enrolled in fee-for-service Medicaid. In a study conducted by a researcher in the Harvard Medical School that used national data (Medical Expenditures Panel Survey), no savings were measured between enrollees residing in MCO counties and fee-for-service counties.[58] Certain services were found to cost more in managed care counties, such as pharmaceuticals and medical care.

As a matter of policy, CMS recognizes managed care as a source of cost savings, specifically for the aged, blind and disabled populations. When a state applies for a Section 1115 demonstration waiver, it must show that the changes to its Medicaid program will have no impact on what the state would have spent absent a waiver. This requirement is known as budget neutrality. Many states have assured CMS that they would achieve this goal by enrolling populations in managed care, while at the same time expanding the eligibility requirements for the program. CMS has regularly accepted the assumption that managed care saves money as compared to a fee-for-service service delivery system. In fact, the recently approved California "Bridge to Reform" waiver included the state's proposal for enrolling the aged, blind and disabled population in managed care with an expectation of cost savings over time.

The "Options" section of this report includes some guidelines and references to materials that may be helpful as Washington further develops its procurement strategies to move high-cost, high-risk enrollees into managed care.

[56] Center for Health Care Strategies (2002). *Serving the special program/aged, blind, and disabled population through managed care.* Schaller Anderson, Inc.

[57] Verdier, J. et al. (2009). *SoonerCare 1115 waiver evaluation: final report.* Washington, D.C.: Mathematica Policy Research, Inc. Retrieved from http://www.chcs.org/usr_doc/6492_SoonerCare_Report_-_Final_-_January_2009%5B1%5D.pdf

[58] Burns, M.E. (2009). Medicaid managed care and cost containment in the adult disabled population, *Medical Care* 47(10): 1069-1076.

VI. OPTIONS

Washington has been a leader in program innovation and management, as reflected in numerous initiatives underway to constrain costs. Options for immediate, short term savings are limited but not unavailable. Any options policy makers choose to pursue should be part of a comprehensive strategy to reform payment and service delivery, addressing key issues identified here and aligning incentives for providers to control costs, encourage use of preventive services, and offer effective community-based programs to avoid higher-cost hospital care. Many of the basic building blocks for such a strategy are already in place in Washington.

HOSPITAL-RELATED OPTIONS

The data included in this analysis and the findings of the Navigant report identify several areas for potential cost savings related to hospital care. It is not immediately evident whether reimbursement rates that appear somewhat high by national standards have resulted in improved value over volume; ED use, readmission rates and rates of sepsis in the state's hospitals remain concerns. As the state confronts its challenging budget, it is worthwhile to review hospital reimbursement levels, hospital acquired conditions, preventable hospitalizations, selective contracting, reducing ED use and enrollee co-payments as promising cost containment strategies.

A. Keep Reimbursement on the Table

As noted earlier, the Ninth Circuit Court of Appeals decision from *Independent Living Center of Southern California v. Maxwell-Jolly* enjoined provider cuts because the state did not base the adjustments on detailed cost studies showing that the resultant rates were reasonably related to the providers' costs of providing the services.[59] The recent Navigant Consulting report warns Washington to take heed of the Ninth U.S. Circuit Court of Appeals decision regarding state methodologies to reduce provider payment, particularly that Medicaid rates must "bear a reasonable relationship" to the costs that "efficient and economical" providers incur in furnishing "quality services."[60] While the ruling limits a state's ability to make arbitrary cuts to provider reimbursement, it allows for changes in reimbursement when the state provides methodology supporting the change proposed. The federal Amicus brief filed in the case signaled flexibility for states and indicated new federal rules are forthcoming.

Navigant's results suggest that there may be room for the state to reduce payments and still meet the Ninth Circuit standards, and the new federal rules should provide more guidance. Cutting hospital reimbursement rates is made more challenging by the existence of the hospital assessment program. The assessments will cease to be imposed if five discrete conditions are not met: One is that Medicaid inpatient and outpatient payment rates cannot be reduced below levels specified in the Act; another makes clear that the fund cannot supplant other funds.[61]

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[59] *Indep. Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly*, 590 F.3d 725 (9th Cir. 2009).

[60] Navigant Consulting (2011), op. cit.

[61] Washington State Legislature (2010). *House Bill Report E2SHB 2956.* Olympia, WA: Washington State Legislature. Retrieved from http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bill%20Reports/House%20Final/2956-S2.E%20HBR%20FBR%2010.pdf.

In times of profound budget pressure the state could amend the law to allow it to lower rates, eliminate the matching provision of some or all of the tax, or reduce inpatient rates in order to increase other rates to invest in community and outpatient activities that will reduce or prevent hospital use.

The assessment law includes provisions to give additional Quality Incentive Payments to hospitals to support evidence based treatments, effective purchasing strategies and various quality initiatives, starting in 2013. Given the budget, those incentive payments should be carefully targeted at strategies that reduce hospital costs and assure accountability for those cost reductions. Conversely, funds allocated for Quality Incentive Payments could be redirected to support community activities that help to prevent avoidable hospitalizations or inappropriate ED use, discussed later in this section.

If Washington opts to cut reimbursement to hospitals, a critical step toward achieving compliance with the Ninth Circuit ruling is to measure current hospital payments and their relationship to costs, reimbursement from other payers (e.g., Medicare), quality and access. The state's legal counsel should be consulted to determine if any planned reductions appear to meet the standards, as best can be determined in the absence of further guidance from the courts or federal rulemakers.

For the long-term, Washington may wish to begin a re-examination of its APC payment methodology for outpatient care. According to one recent study, Enhanced Ambulatory Patient Groups (EAPG), which provide for more bundled payments than APCs, "provide the strongest cost control incentives and the highest degree of purchasing clarity."[62] New York State's Medicaid program moved to EAPGs as part of a broader payment reform effort that was designed to lower inpatient costs and redirect funds to outpatient care as a result. Washington may wish to track New York's on-going experience with EAPGs to determine whether and how outpatient cost savings are achieved and sustained. Moreover, as providers move to form accountable care organizations (ACOs), appropriate methods of payment will need to be developed; federal opportunities exist to seek grants to support the development of bundled payment rates and global budgets to assure consolidation yields improved care, reduces potentially avoidable hospitalizations and keeps cost in check.

Another option may be to work with other payers in the state to negotiate hospital rates, providing the state with greater benefits and a stronger position of negotiation in the hospital services market. If the programs of the Medicaid Purchasing Authority (i.e., Medicaid, BH, MCS and the state employee) collaborated with some of the larger private employers in the state to negotiate rates, the resulting affiliation would carry substantial leverage in the market. This strategy could potentially counter hospital consolidation and should result in significant cost containment.

B. Focus on Adverse Events / Hospital-Acquired Infections

Reducing septicemia and other hospital-acquired infections, as well as complications from care, could help to bend the cost curve for inpatient care. Hospital acquired conditions and adverse events are preventable actions that compromise patient care and require remediation and costs to address. Since 2006, Washington has had a law in place requiring facilities to report adverse events ("never events" and hospital acquired conditions) to the Department of Health, although there were no direct sanctions

[62] Quinn, K. & Courts, C. (2010). *Sound practices in Medicaid payment for hospital care*. Hamilton, NJ: Center for Health Care Strategies. Accessed at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261182

associated with that law. The Department of Health could cite or sanction a facility for adverse events only if it found such an event during a licensing review or in response to an investigated complaint which had not been previously reported. DSHS officials indicated that there were 652 events reported statewide for all payers—not limited to Medicaid—from Calendar Year 2006-2009.

In October 2010, HHS approved a state plan amendment that authorized Washington's Medicaid agency to disallow payment for hospital acquired conditions and adverse events, as defined by the National Quality Forum, and as reported to the Department of Health. The plan took effect January 1, 2011. Washington will no longer pay hospitals for "never events," as defined by the National Quality Forum. It is unclear what, if any, cost savings the state budgeted as a result of this new non-payment policy but implementing the new policy appears to present some challenges. DSHS officials noted that hospitals have already been reversing or not billing for high profile adverse events (e.g. patient death from medication error). Based on the 652 events reported statewide over four years, DSHS officials also noted that will most likely mean less than 100 affected claims per year out of more than 80,000 Medicaid admissions.

Washington's system of reimbursing hospitals, diagnosis related groupings (DRGs), provides for extra payments for complications beyond the standard DRG rate. To enforce the adverse event reporting requirement, Medicaid can disallow those added payments for complexities in the case of an adverse event. The language defining hospital-acquired conditions and adverse events echoes that of Medicare which has had a provision of non-payment in place.

Identifying hospital acquired conditions presents additional challenges: Washington's former Medicaid Management Information System (MMIS) did not capture the "present on admission" indicators necessary to separate such conditions, and not all hospitals were reporting as of the launch of the current ProviderOne MMIS system. DSHS officials are working with their data to better capture and code these conditions. Currently, the process requires post-payment review to determine which claims should be coded to a lower DRG. This type of "pay-and-chase" system is less desirable than a more proactive approach, but that will take time and resources to develop.

However, as a result of requirements in the Affordable Care Act, CMS issued proposed rules on February 17, 2011, governing the non-payment of adverse events in state Medicaid programs. Comments were due in mid-March, and final rules will follow. States must identify claims for non-payment and provider self reporting. CMS proposes using the Medicaid claims system as a platform for collecting data and reporting non-payment. States are required to use the same list of reportable events that Medicare uses, but may go beyond it.

Adverse event reporting is considered first and foremost a quality assurance and improvement initiative, designed to protect patient safety. However, the array of events and conditions that must be reported suggest that there may be additional cost savings that Washington may be able to project and track.

C. Focus on Preventable Hospitalizations

The Navigant report cited relatively high inpatient occupancy rates compared to the region. Are higher occupancy rates in part due to hospitalizations that are potentially avoidable? A recent study showed that reductions in potentially avoidable hospital admissions and in high-variation, high-cost outpatient

services could create savings of over $350 million in annual health care expenditures in Maine.[63] Some of the preventable hospitalizations driving costs in Maine included bacterial pneumonia, adult asthma, COPD, congestive heart failure and diabetes, which appear similar to many of the high-cost acute care admissions in Washington's fee-for-service Medicaid program.

The literature suggests that financial incentives can induce changes in quality and that progress can be made on reducing readmissions.[64]

D. Selective Contracting

Selective contracting has been discussed for nearly 30 years as a policy option for cost containment in Medicaid. In the context of Medicaid, selective contracting for inpatient services is a cost containment option whose objective is to spur competition among hospitals on the basis of price without tradeoff in quality, and thereby produce savings for the state Medicaid program. Despite this discussion, it has rarely been implemented by the states. Among states, California remains the first adopter of Medicaid selective contracting and the most prominent and well-studied example of this cost containment approach. In July, 1982, California's Medicaid program (Medi-Cal) was authorized to contract with individual hospitals for inpatient services at prices to be negotiated between the state and the hospital. The program was enacted in response to the national recession of the early 1980s and the severe budgetary crises affecting California and other states. California's actions spurred the adoption of selective contracting among both public and private-sector plans nationwide. The state has been operating the program under a Medicaid section 1915(b) waiver since 1982.[65] A later study, which looked at program effects of Medi-Cal over the span of two decades found that the savings arising from the Medi-Cal program appeared to be a temporary phenomenon.[66]

Washington State has previously used selective contracting as a cost containment strategy. Between 1988 and 2007 the state contracted with hospitals in the large urban areas to receive non-emergency admissions. According to Department of Social and Health Service staff, the program produced a net savings of between $7 and $12 million each year after taking the cost of operating the program into account. Under this program, the inpatient hospital Diagnosis Related Group (DRG) methodology was based on hospital specific data. The program ended when the state adopted new payment rates for hospitals in 2007. While returning to selective contracting for hospitals seems unlikely at this time, it may be an option in a number of other services such as durable medical equipment (DME) or medical transportation.

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[63] Health Dialog (2009). *All-payer analysis of variation in healthcare in Maine* (Report to Dirigo Health Agency's Maine Quality Forum and Advisory Council on Health Systems Development). Accessed at www.mainequalityforum.gov/HDAS%20MQF%20Report_FINAL%205.1.09.pdf

[64] Jha, A. K., Orav, E. J., & Epstein, A. M. (2010). The effect of financial incentives on hospitals that serve poor patients. *Annals of Internal Medicine, 153*(5), 299-306. doi:10.1059/0003-4819-153-5-201009070-00004

[65] Robinson J.C., & Phibbs, C.S (1989). An evaluation of Medicaid selective contracting in California. *Journal of Health Economics*, 8: 437-455.

[66] Bamezai, A., Melnick, G.A., Mann, J.M., & Zwanziger, J. (2003). Hospital selective contracting without consumer choice: what can we learn from Medi-Cal? *Journal of Policy Analysis and Management,* 22(1), 65-84.

E. Reduce Inappropriate Use of Emergency Departments

Most Medicaid patients do not use emergency departments (EDs) in a given year, but the cost per use is relatively high and small numbers of patients are frequent users. As discussed earlier in this report, use of EDs for non-urgent care has long been a concern in Washington and many other Medicaid programs, as well as the health care system generally. The Washington State Health Care Authority and DSHS issued a comprehensive report on this topic for the legislature in 2007.[67]

One common way states have tried to reduce inappropriate ED use is by requiring cost sharing for non-urgent use of EDs. As of 2008, 36 states including Washington had state plans for Medicaid that allowed cost sharing for non-urgent ED use or for hospital outpatient care more generally. Most are fixed dollar co-payments, although some use co-insurance (a percentage of the payment for services).[68]

Lengthy federal regulations guide cost sharing, which can vary based on an enrollee's income, eligibility category, and the type of service involved. For most services, states cannot apply co-payments for children with incomes under 100 percent of the federal poverty level (FPL) and cost sharing for most adults with incomes below 100 percent of the FPL must not exceed "nominal" levels – defined as $3 plus an inflation adjustment. Certain other groups including pregnant women and individuals in institutions are also exempt from cost sharing in most cases. Even so, groups otherwise exempt from cost-sharing can be charged nominal co-payments for use of EDs for non- emergency services, subject to additional federal requirements concerning appropriate screening, notification of the patient, and availability of alternative providers without cost-sharing requirements.

A thorough analysis conducted in 2008 for Texas Medicaid concluded that a co-payment policy for non-emergency use of EDs would not be feasible or cost-effective due to several factors:

- Implementation challenges and increased administrative costs due to complex requirements;
- The very high percentage of Medicaid patients in Texas with incomes under 100 percent of the FPL, who could not be required to pay co-payments; and
- The lack of available alternative and accessible Medicaid providers, which could limit the number of times co-payments can be applied.[69]

GW understands that DSHS does not currently use its authority to apply co-payments for EDs for many of these same reasons. There is very little research focused on the effects on ED use and payments specifically from nominal co-payments in Medicaid; most studies focus on other services or involve larger co-payments for higher-income Medicaid populations. Results of one recent study suggest that requiring copayments for non-urgent visits does not decrease ED use by Medicaid enrollees.[70]

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[67] Washington State Health Care Authority & Washington State Department of Social and Health Services. (2007.) *Reducing unnecessary emergency department use.* Report to the legislature as required by Engrossed Substitute Senate Bill 5930. December 1.

[68] Kaiser Family Foundation (2009). *Benefits by service: outpatient hospital services (October 2008)* Medicaid Benefits: Online Database. Accessed at: http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=4&cat=12&sv=27.

[69] Health Management Associates (2008). *Co-pays for nonemergent use of hospital emergency rooms: cost-effectiveness and feasibility analysis.* Report to the Texas Health and Human Services Commission. May.

[70] Mortensen, K. (2010). Copayments did not reduce medicaid enrollees' nonemergency use of emergency departments. *Health Affairs, 29*(9), 1643-1650. doi:10.1377/hlthaff.2009.0906

Attempting to reduce ED expenditures by targeting enrollees with high ED utilization is a strategy that Washington can implement and which could produce quantifiable savings: federal rules allow states to limit the amount, scope and duration of services in Medicaid, which includes capping the number of ED visits. Currently, eight states place explicit limits on ED use. These models include capping the number of visits or dollars spent per year on non-emergent care or capping the number of any type of ED visit regardless of whether it is classified as emergency or not.[71]

Limiting non-urgent use of EDs could provide an incentive for hospitals to educate individuals and, ideally, to develop alternatives for Medicaid beneficiaries seeking primary care in EDs. In addition, the state could require that MCOs adopt similar policies in reimbursing hospitals for non-urgent ED use. Changes in reimbursement provide a substantial incentive to act to prevent the inappropriate use of the emergency departments and can be developed in ways that accommodate EMTALA, the federal rules that require hospitals to screen all who enter the ED. A recent literature review on ED use for Maryland Medicaid identified several studies indicating that less ED use and lower costs resulted from extending office hours at primary care practitioners' offices, increasing access locations, care coordination, lower ratios of active patients per clinician hour of practice time and telephone triage systems, and other activities that usually occur outside of hospitals.[72]

Several states are experimenting with strategies to divert non-emergent cases from the ED that are more comprehensive than limiting visits or reimbursement. In New Hampshire, for example, new rules are in process to limit ED visits to four per year and outpatient, non-emergent visits to eight. However, the state is structuring the initiative to exempt physician services provided in the ED. The state will pay for physician services, not a more costly ED visit, to assure they are paying for actual services provided regardless of the care setting. Other states have encouraged hospitals to create urgent care centers, reimbursed at lower rates than the EDs, to deal with non-emergent cases.

New York, which has an ED co-payment for higher income children, has focused on reimbursement incentives and will reduce base premium payments to MCOs account for "Low Acuity Non Emergent (LANE)" visits. Plans will see reductions in their rates for ED visits deemed avoidable. In Louisiana, which has a limit of three ED visits per year for members over age 21, those involved in the state's Primary Care Case Management (PCCM) program are exempt from the limits. Instead, similar to New York, ED use is as a factor in determining bonuses paid to PCCM providers.

Any such programs require careful planning and design. Not all non-emergent use of EDs may be inappropriate.[73] Medicaid members seek ED help for an array of reasons, such as lack of transportation or ability to seek care during working hours; unavailability of providers during early mornings, evenings and weekends; drug seeking behavior; and chronic illness, including behavioral health, that is not well managed. Preventing inappropriate use of ED and avoidable acute care admissions and readmissions requires a more responsive service delivery system and payment reforms to support such a system.

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[71] Kaiser Family Foundation (2009). Op. cit.

[72] Fagan, P., & Sherry, M. (2009). *Emergency department utilization by medicaid enrollees: Defining the problem and reviewing the strategies.* (PowerPoint Presentation) Baltimore, MD: Johns Hopkins HealthCare.

[73] Stanley, R., Zimmerman, J., Hashikawa, C., & Clark, S. J. (2007). Appropriateness of children's nonurgent visits to selected Michigan emergency departments. *Pediatric Emergency Care, 23*(8), 532-536. doi:10.1097/PEC.0b013e318128f84a

Washington may be able to initiate additional delivery and payment reforms that restructure payment and invest in primary care. For example, hospitals could be reimbursed only for physician services when providing non-urgent care and MCOs and primary care providers, including patient centered medical homes, could receive lower rates for ED use that is non-urgent. Funding now appropriated for Quality Incentive Payments could be used to instead provide incentives to assist providers meet needs in the community and avoid ED use by supporting telephone triage lines and more appropriate and timely access to primary care. The scope of this report did not allow a full examination of how Washington is addressing the non-urgent use of EDs, but initiatives in other states may provide practical models for additional reforms in Washington.

TARGET HIGH-COST HEALTH CARE USERS AND DEVELOP SERVICE DELIVERY AND PAYMENT REFORMS TO MORE EFFECTIVELY MEET THEIR NEEDS

A. The Promise of Information Technology

One particularly promising tool DSHS developed in its quest to improve care management is PRISM, an electronic database of Medicaid enrollees and their utilization patterns. This rich tool, demonstrated to GW by DSHS, offers myriad ways to examine service use by Medicaid enrollees in fee-for-service and managed care plans. It is more than just a simple data warehouse; it helps identify and profile frequent care users in numerous, well-defined populations. The tool calculates risk scores for individuals based on diagnoses and service use, including their prescription histories. Other capabilities built into PRISM include a model that estimates whether ED use is non-emergent, likely or possibly treatable in a primary care setting, or emergent non-avoidable; assessments for long-term care users including functional limitations, behavioral concerns, documented falls, reported pain problems, and other elements; and care management tools available to foster care managers and foster parents to help coordinate and better manage care for these children.

PRISM can help the state and its contractors select the most appropriate populations for care management approaches by examining the patterns and prevalence of chronic conditions, clusters of conditions (co-morbidities), and medical and behavioral health utilization of high-risk, high-cost users. For example, Molina Healthcare of Washington uses the tool extensively as part of its management of individuals enrolled in the Washington Medicaid Integration Partnership. Community Health Plan of Washington uses PRISM for the Disability Lifeline program.

DSHS officials remarked that demand from providers currently overwhelms the state's capacity to fulfill all the requests. While not an electronic health record—for example, there are no doctor's notes or lab results in the system—PRISM offers a thorough, retrospective analysis of patterns of care and its risk scores and targeted assessment capabilities provide tools for the state and other users to predict future patterns of care and spending. Importantly, it also allows the state to identify patients with greatest need for care coordination and to monitor subsequent care for those patients, which can help the state assess accountability of plans as more high-risk enrollees move into managed care.

Washington also has experience with more traditional "predictive modeling" from its chronic care management demonstrations. These data-driven models estimate an individual's potential future

health care use and costs based on demographics, healthcare claims, and utilization. As Washington develops more targeted care management approaches for specific groups of Medicaid enrollees, the importance of predictive modeling is apparent. Research from New York Medicaid indicates that, with existing data, it is possible to identify with reasonable accuracy patients at risk of hospital admission in the next twelve months, especially in high-risk populations such as adult SSI and seriously and persistently mentally ill patients. The same research also suggests that sizable net savings are possible with relatively modest assumptions about the ability of interventions to affect future hospitalizations.

Lastly, Washington included a broad range of oversight and payment integrity capabilities in its new Medicaid management information system (MMIS) known as ProviderOne and new Fraud and Abuse Detection System (FADS). These include tools to reduce costs through enhanced fraud detection and recovery, better pursuit of third-party liability, and improved care management. DSHS officials also envision that the new system can improve forecasting and program monitoring, identify the most promising policies, programs and services and provide for better oversight of MCOs. Not all of these capabilities have been fully implemented at the time of this writing, and may require additional investment in terms of financial and personnel resources. As part of this study, GW could not assess the impact of any tools that have already been implemented due to the relatively short period that the system has been operational. Nonetheless, it is generally accepted that investments in technologies such as these can produce savings sufficient to offset the initial investment.

B. Strengthen Care Management

With the capacity provided by PRISM and other technologies to target high-cost, high-risk populations, Washington State should continue moving towards implementing broader care management for those populations, including persons with disabilities. While it is uncertain to predict savings from such a program change—and the Medicaid Purchasing Authority is not assuming savings from managed care for SSI beneficiaries, at least initially—it is likely that there will be health benefits and potential cost savings to the state from implementing a coordinated care program as compared to the existing fee-for-service program. Development of effective care management programs will likely require investment in staffing and infrastructure (e.g., technology) to support these programs.

To generate savings, new care management programs must target the right people, rely on proven interventions, and do so at a low cost. For example, experts maintain that states must introduce integrated management of physical and mental health services for SSI beneficiaries with severe and persistent mental illness to achieve better outcomes at more reasonable cost.[74] Programs need not necessarily be comprehensive managed care in fully capitated plans; enhancing fee-for-service through primary care case management programs may also provide benefits.

As documented in the literature, most Medicaid members with disabilities usually have multiple chronic illnesses. Co-morbidities are pervasive among the highest cost Medicaid-only (non-dual eligible) persons with disabilities. Members with chronic physical illnesses are more likely to be hospitalized if they also have mental health and substance abuse disorders. Washington has relatively high 30-day readmission rates, so efforts to focus on community care for these populations and divert hospitalization are important. The Center for Health Care Strategies has recently completed a literature review that

[74] Bella, M., Somers, S.A., & LLanos, K. (2009). *Providing behavioral health services to Medicaid managed care enrollees: Options for improving the organization and delivery of services*. New York, NY: United Hospital Fund.

documents interventions that appear to work and reduce costs such as primary care teams, case management, preventive home visits, transitional care and Hospital at Home. Washington's King County Partners demonstration provides an example of such an intervention. It may be appropriate to redirect funds from acute care, where rates appear to be higher than many states, to further invest in strategic efforts to provide care that prevents avoidable ED and acute care use.[75]

In developing new approaches, Washington can draw on a growing body of evidence from its own experiences managing care for high-risk populations and the experiences of other states. Existing models differ in their approaches. Fully-capitated plans that put providers at most risk also tend to give providers more freedoms; partial- or non-risk models require different ways of balancing flexibility and control with risk and accountability.[76] For example, states give varying levels of medical management authority to contractors. Determining which functions have the most impact on quality and cost, and how various management tools interact, is important in determining both the structure of medical management authority and setting performance expectations.[77] The scope of provider networks and flexibility of interventions are also important considerations. The Center for Health Care Strategies recently published a set of core elements for integrated care models, which includes:

- Stratification and triage by risk/need;
- Integration of services;
- Designated "care home" and personalized care plan;
- Consumer engagement strategies;
- Provider engagement strategies;
- Information exchange among all stakeholders, including consumers;
- Performance measurement and accountability; and
- Financial incentives aligned with quality care.[78]

Washington should also consider expanding care management options for dual eligible Medicaid and Medicare beneficiaries, such as the Washington Medicaid Integration Project. States generally rely on Medicare dual eligible special needs plans (SNPs) for coordination of care for this population, but these plans remain limited. North Carolina is developing a program that will rely on local provider networks, building on the state's existing enhanced primary care case management program (Community Care of North Carolina). Federal demonstration projects with shared savings for Medicare and Medicaid are possible avenues for Washington to pursue, as the federal government also looks to contain costs in these programs. The Center for Medicare and Medicaid Innovation at CMS is likely to test models fully integrating care for dual eligibles. In April, CMS announced that Washington would receive a $1 million grant to integrate care for dual eligibles. Under this grant, the state will produce a multi-phase plan to better serve dual eligibles and reduce the cost of health care for this generally high-cost population.

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[75] Boyd, C., Leff, B., Weiss, C., Wolff, J., Clark, R., & Richards, T. (2010). *Clarifying multimorbidity to improve targeting and delivery of clinical services for Medicaid Populations.* Hamilton, NJ: Center for Health Care Strategies, Inc. Accessed at http://www.chcs.org/usr_doc/Clarifying_Multimorbidity_for_Medicaid_report-FINAL.pdf.

[76] Bella, M., Shearer, C., LLanos, K., Somers, S.A. (2008). *Purchasing strategies to improve care management for complex populations: A national scan* of *state purchasers*. Hamilton, NJ: Center for Health Care Strategies, Inc. Accessed at http://www.chcs.org/publications3960/publications_show.htm?doc_id=674878

[77] Ibid.

[78] Center for Health Care Strategies, Inc. (2010). *Medicaid best buys: critical strategies to focus on high-need, high-cost beneficiaries*. Hamilton, NJ: Center for Health Care Strategies, Inc. April.

C. Continue to Improve Maternity Care

While pregnant women as a group are not generally high risk and high cost, the impact of low birth weight and prematurity incurs significant immediate costs in NICU units and long term costs for care of compromised babies. Identifying specific methods Washington Medicaid can use to reduce costly complications such as infant mortality and low birth weight is beyond the scope of this analysis, and time constraints made it impossible to produce and review data about NICU costs in the state, but the importance of pregnancy, childbirth, newborns and new mothers raise some potential issues and opportunities. And it raises the policy question about the role and impact of managed care, given that about 60 percent of the state's population of Medicaid-enrolled pregnant women is in managed care.

According to the March of Dimes, premature births cost ten times more than healthy births. While there is no one cause of prematurity and low birth weight, some of the leading causes include: previous delivery of a preterm or low birth weight baby; carrying multiple fetuses; smoking and drug use; and mother's weight. Low income, less educational status, and race are also indicators, with African American and Hispanic women more likely to have premature births.[79] The majority of babies in costly Neonatal Intensive Care Units result from prematurity. Prior research indicates that increased supply of primary care practitioners—especially in areas with high levels of social disparities—reduces the incidence of infant mortality and low birth weight.[80]

Washington has a long history in identifying and addressing the importance of family planning and prenatal care. Most recently, First Steps and the Maternal Support System target interventions to improve prenatal care and birth outcomes and the state has launched an effort to reduce Cesarean section births by reducing the DRG and, in 2112, putting hospitals at risk, in order to encourage lower Cesarean section rates. Officials noted that elective Cesarean section and less than 39 week deliveries drive NICU admissions and have proposed to use planned quality incentive payments to hospitals as a tool to decrease these outcomes.[81] A pilot project, Reducing Elective Delivery Before 39 Weeks, is underway through the Washington State Perinatal Collaborative. The department also is in the process of reviewing nursery transfer policies that also drive NICU costs. In addition, state officials report that Washington has the highest rate of lower cost birthing center and home births in the U.S., although they account for only about 3 percent of total births.

The First Steps and MSS program have been regularly evaluated. It appears that the programs generally have marginally reduced the occurrence of low-weight births (one half percentage point) but have little effect on the incidence of preterm births, with the notable exception of Hispanic women for whom both low birth-weight babies and preterm deliveries have been reduced.[82] One report showed a positive impact on women who were substance abusers as well.[83] State officials report that the program

[79] Hall, E. & Berlin, M. (2004). *Using Medicaid to support preterm birth prevention: Five case studies*. (Report to the March of Dimes) Accessed at http://www.marchofdimes.com/advocacy/prevention_pretermcasestudies.html

[80] Shi,L., Macinko,J., Starfield,B., Xu, J., Regan,J., Politzer,R. & Wulu, J. (2004). Primary care, infant mortality, and low birth weight in the states of the USA. *J Epidemiol Community Health*. 58(5), 374–380.

[81] Washington State Department of Social and Health Services (2010). *Report to the legislature: hospitals safety net assessment quality incentive payments methodology.* Olympia, WA: DSHS.

[82] Arimaa, Y., Guthriea, B., Rhewa, I. & De Roosb, A. (2009). The impact of the First Steps prenatal care program on birth outcomes among women receiving Medicaid in Washington State. *Health Policy.* 92(1), 49-54.

[83] Cawthon, L. (2006). *The first steps program: 1989-2004.* First Steps Database Fact Sheet Number 9.82. Olympia, WA: Department of Social and Health Services, Research and Data Analysis. May.

operates at about $15 million (state and federal) and results in avoided costs of about $4 million (state and federal) per year. The budget has recently been reduced by 35 percent. In addition, the state pays an enhanced rate to federally qualified health centers (FQHCs) that participate in the MSS program. According to state officials, the differential was about $25 million (state and federal) for FY2009, using the Alternative Payment Methodology rates currently applied to FQHCs.

To cope with budget reductions, MSS will cap units of service based on risk factors. The program is voluntary and the state reports that it serves about 70 percent of low-income eligible pregnant women; targeting by risk has previously been a part of the program effort but a redoubling of that work may lead to identification of higher risk pregnant women and better avoidance of prematurity and NICU use. One assumes that tiering by risk now underway in MSS will directly address the specific risk factors for prematurity and low birth weight, noted above, and will hold providers accountable for outcomes (e.g. reduced prematurity; reduced NICU use, etc.).

While Washington has demonstrated significant leadership in these efforts, other states' experiences may inform their efforts. Hall and Berlin reported on five case studies of programs that demonstrated an impact on preterm birth rates and improved birth outcomes in Medicaid.[84] Although dated, the results bear review. Florida reported a 9 percent decrease in low birth weight; Louisiana's preliminary data showed a 52 percent lower rate of low birth weight and 50 percent lower ED use; Oregon reduced smoking rates of pregnant women by 28 percent and Rhode Island, by extending family planning and primary care benefits by two years, reduced in half the number of women who delivered another baby within 18 months. Monroe County, NY, reached out to all pregnant women and asked them to complete a health risk assessment to identify high risk. The program then targeted those women and reports a significant decline in NICU rates and associated savings in avoided admissions investment of $2 for every $1 spent.

The Agency for Health Care Research and Quality Innovation Exchange reports that a program offered by Optima Health in Virginia used telephone-based case management and periodic home visits and was able to reduce NICU and overall costs for high-risk pregnant women and their babies.

Certainly, Washington State has experience in most, if not all, of these strategies and will need to consider cost and benefit of any change. But the determination to tier services and focus more on risk, coupled with the opportunity to hold providers accountable for outcomes, holds great promise for continued improvement in Washington's efforts to improve birth outcomes and thereby reduce costs.

D. Consider Palliative Care

Patients at the end of life account for significant health care costs. A recent study of four New York hospitals found that, on average, patients who received palliative care incurred $6,900 less cost per admission than those who did not get that service. Importantly, palliative care improved quality and patients in palliative care were less likely to die in an ICU and more likely to receive hospice care.[85] These results may not translate to Washington's Medicaid program. Not every hospital has the staff expertise or experience in palliative care. However, one possibility might be to build incentives, such as

[84] Hall, E. & Berlin, M. (2004), op. cit.

[85] Morrison, R.S., Dietrich, J., Ladwig, S., Quill, T., Sacco, J., Tangeman, J., & Meier, D.E. (2011). Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs*, 30(3), 454-463.

shared savings, into the managed care contracts for the planned enrollment of persons with disabilities and other populations who are more likely to need such care than the parents and children traditionally served by Washington's Medicaid managed care plans.

E. Maintain Commitment to Evidence-Based Health Policy

Another advantage for Washington in developing new approaches to managing care, reforming the delivery system and refining payment methodologies is its commitment to evidence-based health policy. The state has put in place statutory and administrative tools to support evidence-based decisions for Medicaid and all of the state's publicly-financed healthcare programs. Washington's Health Technology Assessment (HTA) program assesses surgical devices and procedures, medical equipment and diagnostic tests, with the results presented to a clinical committee that makes coverage recommendations. In addition to reducing use of products and services of questionable value, the HTA could potentially increase the use of underutilized services.[86] While the HTA is not without controversy, the opportunities it presents remain significant and will soon be joined by national efforts under the Affordable Care Act.

MAXIMIZE OPPORTUNITES AVAILABLE THROUGH THE AFFORDABLE CARE ACT

Washington is already well-positioned to take advantage of new federal opportunities like the Patient Centered Medical Home Demonstration and other opportunities available through the Affordable Care Act. The Agency for Health Care Research and Quality is launching its center for Comparative Effectiveness Research that will likely be supportive of, but will not duplicate, the work of the HTA, as noted above. The state has also applied for demonstration funding to better manage care for dual eligibles and awaits federal decisions on which states will receive funding in that very competitive review. Additional Medicaid funding opportunities include case management for chronic illness, pediatric accountable care organizations (ACOs) and payment reform opportunities such as bundled payment approaches.

One of the best ways for states to pursue reimbursement and service delivery reforms is to take advantage of the changes in these areas demonstrated by CMS through the new Center for Innovation in Medicare and Medicaid. The Center is pursuing demonstrations by selecting Centers of Excellence from the provider community. These are either integrated health care systems or hospital systems that are interested in testing the new approaches.

Washington's Medicaid program would benefit by teaming up with any Center of Excellence in the state that is a demonstration site for new approaches to reimbursement and service delivery. While such a partnership would not result in immediate savings, it would allow Medicaid to benefit from the findings of such a demonstration while taking advantage of the federal resources for the demonstration. In addition, approval for participation from CMS would be easier to obtain than seeking approval as an independent project of the state.

[86] Franklin, G.M, & Budenholzer, B.R. (2009). Implementing evidence-based health policy in Washington State. *New England Journal of Medicine*, 361(18), 1722-1725.

VII. CONCLUSIONS

This analysis finds that small numbers of users account for most fee-for-service spending for inpatient and outpatient services. Persons with disabilities are frequent users of these services, and generally among the leading drivers of fee-for-service Medicaid spending. However, this group itself encompasses a diverse range of critical acute care needs and chronic conditions, both physical and behavioral, which are prevalent among low-income persons with disabilities.

Pregnant women are also among the leading users of fee-for-service inpatient spending. While costs for this group are generally low relative to other groups using fee-for-service care, high-cost cases contribute disproportionately to the overall spending on inpatient services for pregnant women. These high-cost fee-for-service cases typically involve complications mainly related to pregnancy or occurring mainly in the course of labor and delivery.

Concentration of fee-for-service spending among high-cost cases is not unique to Washington Medicaid.[87,88,89] Across the country, states and other health care payers are searching for solutions that improve care, improve the health of covered populations, and reduce per capita costs. However, these solutions are unlikely to develop quickly enough to avert Washington's current fiscal crisis. In the short term, the state will likely need to reduce costs by focusing on more blunt options offering short-term savings such as reducing reimbursement, placing restrictions on benefits and instituting cost-sharing for beneficiaries. These short-term solutions may sometimes be at odds with long-term goals of improving care management, but may be unavoidable given the current state budget constraints. Where evidence shows that current care management practices and tools already in use in Washington Medicaid save money, expansion of these efforts could also produce savings for the next biennium.

Long-term solutions to bend the curve will require concentrated, coordinated care management for high-use, high-cost Medicaid beneficiaries and strategic approaches to reform the service delivery system, with accompanying payment reform to incentivize change. To generate savings, new care management programs must target the right people, rely on proven interventions, and do so at a low cost. Washington can draw on a rich history of past and present efforts in the state to improve care and reduce costs, as well as the experiences of other states. It is important that these efforts be part of a larger effort within the state (and across the country) to apply good care management principles and practices across all health care users, not just those in Medicaid. Furthermore, Washington must exercise caution to not try so many approaches that it spreads its resources—including personnel and funding—too thin. Due to recent administrative reductions, investment in staffing or infrastructure may be required to support new cost containment initiatives. The concentration of spending in high-cost cases highlights the need for targeted solutions, and a clear strategy that can document expected savings across all the initiatives and coordinate all the initiatives into a seamless, coordinated approach to cost containment and quality improvement where results can be clearly measured.

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[87] Schneider, A., Lambrew, J., & Shenouda, Y. (June 2005). *Medicaid cost containment: The reality of high-cost cases.* Washington, DC: Center for American Progress.

[88] Lee, J., & Anderson, T. (May 2005). *High-cost Medicare beneficiaries.* Washington, DC: Congressional Budget Office.

[89] Blumberg, L. J., & Holahan, J. (2004). Government as reinsurer: Potential impacts on public and private spending. *Inquiry, 41*(2), 130-143. doi:10.5034/inquiryjrnl_41.2.130

Given the significant expenditures and growth for long-term care services and supports and managed care, additional examination of those areas could prove promising. Since GW did not obtain encounter data to compare fee-for-service and managed care expenditures, and long-term care was not an area of focus for this report, it is not possible to make any recommendations now.

Washington Medicaid has operational and programmatic policies in place that are viewed nationally as effective tools in restraining cost growth. Moreover, all branches of the state's government show an admirable commitment to providing high-quality, cost-effective care. While tensions are inevitable during periods of fiscal crisis, it is critical that officials throughout the state work together to achieve solutions that recognize the limitations for short-term savings required by current fiscal realities and promote long-term solutions that will better prepare Medicaid and the rest of the state's health care system for the next inevitable downturn.

APPENDIX: RESULTS OF MULTI-STATE INPATIENT HOSPITAL ANALYSIS

Results in this section come from State Inpatient Databases (SID) compiled by the Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). SIDs include inpatient hospital discharge data for all or mostly all payers in each state, including Medicaid. This information includes basic demographics for patients, diagnosis codes, and charges reported on the discharge records. The unit of analysis is the discharge record (representing unique stays), not unique patients.

GW conducted this analysis using calendar year 2007 data from Washington and five other states: California, Massachusetts, New Jersey, Oregon and Wisconsin. These states were selected based on geographic proximity or general reputation as states with comprehensive Medicaid programs. The analysis includes only discharges listing Medicaid as a payer, which includes patients from Medicaid managed care organizations (MCOs) and traditional Medicaid fee-for-service programs.

	Washington	California	New Jersey	Mass.	Oregon	Wisconsin
Age						
Mean	34	39	36	38	33	31
Median	39	42	41	41	37	33
Gender						
Male	28,859 (47.69%)	208,497 (46.43%)	23,824 (46.66%)	37,498 (48.53%)	11,097 (44.33%)	20,519 (42.19%)
Female	31,651 (52.53%)	240,579 (53.57%)	27,237 (53.34%)	39,768 (51.47%)	13,936 (55.67%)	28,120 (57.81%)
Race						
White	No data	133,270 (32.31%)	15,766 (31.45%)	43,619 (58.92%)	No data	28,226 (59.1%)
Black	No data	60,135 (14.58%)	18,612 (37.12%)	11,368 (15.36%)	No data	12,945 (27.1%)
Hispanic	No data	180,932 (43.86%)	11,546 (23.03%)	13,974 (18.88%)	No data	4,063 (8.51%)
Asian/Pacific Islander	No data	27,798 (6.74%)	1,098 (2.19%)	1,856 (2.51%)	No data	875 (1.83%)
Native American	No data	446 (0.11%)	132 (0.26%)	133 (0.18%)	No data	929 (1.95%)
Other	No data	9,902 (2.40%)	2,980 (5.94%)	3,078 (4.16%)	No data	724 (1.52%)
Admission Source						
Emergency department	34,198 (60.30%)	302,717 (64.24%)	27,775 (69.80%)	44,971 (58.41%)	10,236 (54.62%)	19,233 (52.70%)
Another hospital	2,829 (4.99%)	25,221 (5.35%)	1,750 (4.40%)	4,873 (6.33%)	1,872 (9.99%)	2,375 (6.51%)
Other health facility	292 (0.51%)	11,344 (2.41%)	1,372 (3.45%)	1,746 (2.27%)	198 (1.06%)	279 (0.76%)
Court/law enforcement	750 (1.32%)	177 (0.04%)	No data	675 (0.88%)	Too few to report	771 (2.11%)
Routine	18,647 (32.88%)	131,792 (27.97%)	8,896 (22.36%)	24,730 (32.12%)	6,426 (34.29%)	13,840 (37.92%)

	Washington	California	New Jersey	Mass.	Oregon	Wisconsin
Top 20 primary diagnosis codes						
Key: **Code Description #/% of Visits**	296 Episodic mood disorders (2,684/4.44%)	295 Schizophrenic disorders (20,043/4.25%)	295 Schizophrenic disorders (2,821/5.52%)	296 Episodic mood disorders (5,377/6.96%)	296 Episodic mood disorders (844/3.37%)	296 Episodic mood disorders (3,514/7.28%)
2	682 Other cellulitis and abscess (1,924/3.18%)	296 Episodic mood disorders (19,857/4.21%)	296 Episodic mood disorders (2,808/5.50%)	493 Asthma (2,622/3.39%)	486 Pneumonia organism unspecified (703/2.81%)	486 Pneumonia organism unspecified (1,372/2.82%)
3	250 Diabetes mellitus (1,722/2.85%)	786 Symptoms: respiratory system and other chest (14,993/3.18%)	493 Asthma (1,987/3.89%)	682 Other cellulitis and abscess (2,235/2.89%)	250 Diabetes mellitus (697/2.78%)	493 Asthma (1,347/2.77%)
4	486 Pneumonia organism unspecified (1,707/2.82%)	486 Pneumonia organism unspecified (14,423/3.06%)	486 Pneumonia organism unspecified (1,884/3.69%)	486 Pneumonia organism unspecified (2,077/2.69%)	682 Other cellulitis and abscess (681/2.72%)	295 Schizophrenic disorders (1,122/2.31%)
5	493 Asthma (1,349/2.23%)	250 Diabetes mellitus (12,067/2.56%)	786 Symptoms: respiratory system and other chest (1,617/3.17%)	295 Schizophrenic disorders (1,929/2.50%)	466 Acute bronchitis and bronchiolitis (544/2.17%)	786 Symptoms: respiratory system and other chest (1,004/2.06%)
6	466 Acute bronchitis and bronchiolitis (1,281/2.12%)	428 Heart failure (11,487/2.44%)	780 General symptoms (1,379/2.70%)	786 Symptoms: respiratory system and other chest (1,848/2.39%)	493 Asthma (539/2.15%)	682 Other cellulitis and abscess (954/1.96%)
7	786 Symptoms: respiratory system and other chest (1,202/1.99%)	493 Asthma (11,154/2.37%)	276 Disorders of fluid electrolyte and acid-base balance (1,196/2.34%)	250 Diabetes mellitus (1,700/2.20%)	780 General symptoms (480/1.92%)	250 Diabetes mellitus (945.1.94%)
8	295 Schizophrenic disorders (1,073/1.77%)	682 Other cellulitis and abscess (11,017/2.34%)	682 Other cellulitis and abscess (1,193/2.34%)	291 Alcohol-induced mental disorders (1,699 /2.20%)	996 Complications peculiar to certain specified procedures (479/1.91%)	276 Disorders of fluid electrolyte and acid-base balance (941 /1.93%)
9	780 General symptoms (1,060/1.75%)	038 Septicemia (10,175/2.16%)	250 Diabetes mellitus (1,152/2.26%)	304 Drug dependence (1,698/2.20%)	295 Schizophrenic disorders (473/1.89%)	780 General symptoms (912/1.88%)

	Washington	California	New Jersey	Mass.	Oregon	Wisconsin
10	038 Septicemia (1,049/1.73%)	466 Acute bronchitis and bronchiolitis (9,731/2.06%)	428 Heart failure (1,122/2.20%)	780 General symptoms (1,439/1.86%)	276 Disorders of fluid electrolyte and acid-base balance (463/1.85%)	996 Complications peculiar to certain specified procedures (866/1.78%)
11	518 Other diseases of lung (1,017/1.68%)	780 General symptoms (9,526/2.02%)	466 Acute bronchitis and bronchiolitis (1,083/2.12%)	276 Disorders of fluid electrolyte and acid-base balance (1,377/1.78%)	540 Acute appendicitis (451/1.80%)	466 Acute bronchitis and bronchiolitis (858/1.76%)
12	996 Complications peculiar to certain specified procedures (1,003/1.66%)	540 Acute appendicitis (9,207/1.95%)	282 Hereditary hemolytic anemias (999/1.96%)	577 Diseases of pancreas (1,272/1.65%)	786 Symptoms: respiratory system and other chest (402/1.61%)	309 Adjustment reaction (738/1.52%)
13	428 Heart failure (997/1.65%)	574 Cholelithiasis (8,693/1.84%)	292 Drug-induced mental disorders (974/1.91%)	292 Drug-induced mental disorders (1,230/1.59%)	428 Heart failure (394/1.57%)	291 Alcohol-induced mental disorders (662/1.36%)
14	540 Acute appendicitis (979/1.65%)	276 Disorders of fluid electrolyte and acid-base balance (8,093/1.72%)	038 Septicemia (875/1.71%)	428 Heart failure (1,091/1.41%)	518 Other diseases of lung (381/1.52%)	428 Heart failure (646/1.33%)
15	276 Disorders of fluid electrolyte and acid-base balance (865/1.43%)	996 Complications peculiar to certain specified procedures (7,732/1.64%)	042 HIV disease (861/1.69%)	466 Acute bronchitis and bronchiolitis (1,045/1.35%)	038 Septicemia (371/1.48%)	038 Septicemia (644/1.32%)
16	491 Chronic bronchitis (818/1.35%)	V58 Encounter for other and unspecified procedures and aftercare (6,162/1.31%)	491 Chronic bronchitis (818/1.35%)	996 Complications peculiar to certain specified procedures (1,004/1.30%)	491 Chronic bronchitis (343/1.37%)	345 Epilepsy (631/1.30%)
17	599 Other disorders of urethra and urinary tract (780/1.29%)	414 Other forms of chronic ischemic heart disease (6,139/1.30%)	599 Other disorders of urethra and urinary tract (780/1.29%)	309 Adjustment reaction (977/1.26%)	574 Cholelithiasis (334/1.33%)	282 Hereditary hemolytic anemias (620/1.27%)

	Washington	California	New Jersey	Mass.	Oregon	Wisconsin
18	V58 Encounter for other and unspecified procedures and aftercare (772/1.28%)	577 Diseases of pancreas (5,988/1.27%)	V58 Encounter for other and unspecified procedures and aftercare (772/1.28%)	303 Alcohol dependence syndrome (946/1.22%)	V58 Encounter for other and unspecified procedures and aftercare (326/1.30%)	311 Depressive disorder not elsewhere classified (604/1.24%)
19	345 Epilepsy (715/1.18%)	518 Other diseases of lung (5,753/1.22%)	345 Epilepsy (715/1.18%)	491 Chronic bronchitis (913/1.18%)	577 Diseases of pancreas (315/1.26%)	540 Acute appendicitis (600/1/23%)
20	998 Other complications of procedures not elsewhere classified (687/1.14%)	599 Other disorders of urethra and urinary tract (5,712/1.21%)	998 Other complications of procedures not elsewhere classified (687/1.14%)	789 Other symptoms involving abdomen and pelvis (797/1.03%)	998 Other complications of procedures not elsewhere classified (280/1.12%)	303 Alcohol dependence syndrome (567/1.17%)

Source: GW analysis of State Inpatient Databases (SID) compiled by the Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ).

Notes: Patient race/ethnicity is not included in discharge data for Washington or Oregon. "Mass" Is Massachusetts.