The LEWIN GROUP

NORTH CAROLINA MEDICAID BENEFIT STUDY

Final Report

Prepared for:
North Carolina General Assembly

Prepared by:
The Lewin Group

With assistance from:
West Virginia Medical Institute

May 1, 2001

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April 30, 2001

The Honorable Marc Basnight, President Pro Tempore
The Honorable James B. Black, Speaker of the House
North Carolina General Assembly
Raleigh, North Carolina 27601

Dear Senator Basnight and Representative Black:

The Lewin Group, together with West Virginia Medical Institute, is pleased to submit our final report entitled "North Carolina Medicaid Benefit Study." In our report, we studied the process by which North Carolina sets the amount, duration, scope and sufficiency of its Medicaid benefits, and how those benefits are managed.

We appreciate the opportunity to have performed this study for the General Assembly. We greatly appreciate the full cooperation we received from the Fiscal Research Division of the Legislature, and from the Division of Medical Assistance in the Department of Health and Human Services. In the course of this engagement we encountered many dedicated, skilled and professional public servants in the Medicaid program. This augurs well for the future of North Carolina's Medicaid program, and for the care it will continue to deliver to the state's Medicaid beneficiaries.

The report concludes that North Carolina has succeeded in designing a benefit package that encourages access to a comprehensive set of benefits for a very vulnerable population. The report notes that the development and management of benefits within North Carolina's Medicaid program is affected by political and funding dynamics that are common to Medicaid programs. These dynamics include decisions to seek federal funding for otherwise state-only funded services (such as mental health and special education); policy-making roles for multiple agencies, providers and other groups; and lean administrative resources to manage a multi-billion dollar program.

Our report makes several recommendations. We encourage the state to implement a stronger utilization management program for its pharmacy program, which would save the state substantial funds. We recommend other utilization management tools that also will save money and improve health care in the long run. We encourage the state to continue its ongoing efforts to reduce the fragmentation in its process, and to re-evaluate the roles played by public providers, particularly the Area Mental Health Authorities, which enjoy preferential treatment. And although our study was not designed with a cost containment emphasis, should the state want to save money we recommend re-visiting the decision to raise physician fees to 100% of Medicare: data we analyzed showed no discernible health care benefit as a result of this increase, as measured by access to care or provider participation in Medicaid.

Respectfully submitted,

Charles J. Milligan, Jr.
Vice President

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EXECUTIVE SUMMARY

In most states it is common to hear that the Medicaid program offers a "Cadillac" benefit package to its beneficiaries. In many ways this observation is true: unlike private insurance Medicaid offers a comprehensive pharmacy benefit, a variety of long term care options including community-based care, non-medical transportation, and other benefits not frequently offered in the private insurance market.

But it is also true that the catchy use of the "Cadillac" comparison masks important points about Medicaid. For one, federal Medicaid law mandates that states offer certain services that exceed the benefits available through private health insurance plans, such as the comprehensive pediatric health screening process known in Medicaid as "Early and Periodic Screening, Diagnosis and Treatment," or EPSDT. States must provide those federally mandated benefits. For another, the poverty and disability status of many Medicaid beneficiaries necessitates including services that are not needed by a generally healthier and wealthier population in a private insurance plan.

In late 2000, the North Carolina Legislature commissioned this study to look in-depth at North Carolina's Medicaid benefit package. The Legislature wanted to know whether the process by which benefits are added to (or subtracted from) the Medicaid benefit package makes sense. It wanted to know how well these benefits are managed by the state's Medicaid agency: does it adequately enable people who need the benefits to get them, while simultaneously avoiding utilization of services by beneficiaries who do not need them. The Legislature wanted to know how North Carolina's benefit package and approach compare to other state Medicaid programs, and to private insurers in North Carolina, and whether these other programs have useful approaches that could be adopted in North Carolina by the Medicaid program.

Our study was conducted from late 2000 through April 2001. Because our study reflects a point in time for Medicaid benefit policy and administration, it is important to note that changes occur over time. The Division of Medical Assistance (DMA), for example, made several changes during the course of our study, including adopting a uniform policy review protocol (in the works before we arrived) and resolving a nursing home admission prior authorization problem.

We found that in many ways the state Medicaid agency is doing a good job. In evaluating whether to add a benefit to the Medicaid package it generally works well with outside stakeholder groups (providers and beneficiaries) to understand when the benefit will be used, and whether and how it will enhance the beneficiary's quality of life. It is willing to say no to requests to add benefits. The agency subjects the potential new benefit to fiscal reviews, and it develops projections on potential costs. For existing benefits, Medicaid often conducts program integrity reviews to audit for potential overutilization.

The Medicaid program is managed by dedicated, skilled and professional public servants in both the Executive and Legislative branches of government. No matter how skilled the managers are, however, a state Medicaid benefit package inevitably looks "messier" than a private insurance product. For example, in North Carolina, as in other states, Medicaid benefits are added (and generally not actively managed) when the provider that is paid for the benefit is another public agency, such as a school (for special education services) or an Area Mental Health Authority (for

behavioral health benefits). These decisions, which expand Medicaid far beyond commercial insurance, are typically motivated by a desire to access federal Medicaid funds to legitimately subsidize otherwise state-only funded health services. Over time the cumulative effect of these decisions can blur the line regarding whether the benefit package is designed to put a package of needed services around Medicaid beneficiaries or whether it is designed to support public providers with revenue. In many cases, the answer is "both."

In our review, we found features in North Carolina's Medicaid benefit process that could be improved. As discussed in more detail in the full report, our key recommendations are:

- **Increase Management of the Pharmacy Benefit.** The vast majority of Medicaid programs and private insurers utilize techniques to encourage the use of generic substitutes when possible. One method is requiring prior authorization to dispense certain medications when less expensive alternatives exist. The North Carolina Medicaid program has a very minimal – many would say non-existent – prior authorization program. Creating such a program for just eight expensive and often-prescribed brand-name drugs that have generic equivalents could realize over $50 million annually in total program expenditure savings, including $16.3 million in state expenditures.

- **Create a Level Playing Field in Behavioral Health.** Access to Medicaid's behavioral health benefits is affected by the numerous preferential policies that exist to serve Area Mental Health Authorities. As noted above, the motivation is legitimate: move federal Medicaid dollars through the Medicaid agency to the Area Programs to displace state and local funds with federal funds. These preferential policies, however well intended, probably go too far in North Carolina, to the point of discouraging private provider participation in delivering behavioral health benefits. Making this playing field more level should increase access to privately provided behavioral health benefits.

- **Reduce the Fragmentation in the Medicaid Benefit Policy-Making Process.** Benefit decision-making in North Carolina's Medicaid program occurs in "silos." Policy staff is assigned to specific benefits, such as inpatient care, behavioral health or independent practitioners. These silos historically have approached benefit decision-making in their own, home-grown ways. This problem is being addressed by the state Medicaid agency through its adoption on March 1, 2001 of a uniform policy protocol across benefit silos. We encourage this process to continue. A problem that is not being tackled, though, is the more forceful inclusion of information systems and program integrity staff in the process. The systems staff may prevent a problem from occurring, namely the adoption of policies that look good on paper but cannot be converted into enforceable computer code (for example developing a policy that prohibits certain duplicate services that *nevertheless are paid by the system* since the claims payment system does not know what constitutes a duplicative service). The program integrity staff have keen knowledge of where fraud and abuse arises in Medicaid, and could offer helpful insights into how those lessons learned should inform future policy-making.

- **Consider Reducing Physician Fees.** The fees paid by North Carolina to its Medicaid providers are much higher than any other state in the region. These fees recently were raised from 91 percent to 100 percent of the Medicare schedule. The rationale for the increase was that it would improve access to care. However, in reviewing the data, we

found no discernible access problem before this increase, nor did we detect an increase in access related to the fee increase. If North Carolina reduced its fees back to 91 percent of Medicare, it therefore should not compromise access (which was no different at 91 percent of Medicare than it is at 100 percent) and the state would save $50.9 million in total funds ($16.5 in state funds). Reducing it further to 85 percent of Medicare – which is equivalent to the highest rate in any adjacent state and substantially higher than South Carolina and Virginia – North Carolina could realize total savings of $84.75 million in Medicaid expenditures, which is $27.6 million in state expenditures. The effect on access at 85 percent of Medicare is unknown.

- **Improve the Use of Data and Medical Literature in the Decision-Making Process.** In any state Medicaid program, benefit decisions are a combination of politics and good literature, research, and/or medicine. This cannot be changed. What can be changed, however, is requiring the use of medical literature, data and outcomes to inform this process, as most private insurers do. North Carolina often adds benefits because it "is the right thing to do," taking a leap of faith the new benefit will help beneficiaries. Increasing the program's medical expertise, perhaps by renewing part-time contracts with outside medical consultants that lapsed a few years ago, and requiring that new benefits be thoroughly supported by data, research and/or literature could mitigate the influence of politics in the benefit design process.

- **Re-Evaluate Whether to Offer Benefits that Are Not Included by Most State Medicaid Programs.** North Carolina's Medicaid benefit package includes a number of benefits not offered by an overwhelming number of state Medicaid programs. Topping this list is the generous length of North Carolina's therapeutic leave policy at nursing homes (60 paid days a year to keep an empty bed reserved for a resident), and the chiropractic and podiatry benefits. These benefits assist many people, and we are not here recommending the termination of these benefits. We do, however, recommend re-evaluating whether North Carolina should pare back where it exceeds the "average" state Medicaid program, such as in these benefits.

- **Improve Coordination of Care and Utilization Review Processes.** North Carolina Medicaid uses the services of multiple utilization review companies that review different aspects of the same general benefit area. For example, ValueOptions, First Health, and the Area Programs all play roles in reviewing the appropriateness of behavioral health benefits. We urge the state to continue the process it began several months ago to better coordinate these roles, and perhaps reduce the number of chefs in the kitchen. We also urge the state to capitalize on the importance of primary care providers (PCP) – who play critical roles as medical homes under Carolina ACCESS – by better linking school-based services to and through PCPs.

- **Strengthen Program Integrity Controls.** The Program Integrity Unit at DMA monitors the program for fraud, waste and abuse. It is often the unit where benefit anomalies are first identified, including problems such as the inconsistency between policies and claims payment system edits. The role of this Unit needs to be better integrated into benefit design and evaluation, and it needs additional resources to help the state cost-effectively eliminate overpayments in areas such as nursing homes, community-based programs, and home health.

Finally, it must be emphasized that this study was not commissioned to identify cost savings in Medicaid. The goal, from the conception of the project by the General Assembly through the submission of this report, was to neutrally evaluate the Medicaid benefits in North Carolina. We honored this goal, to the best of our ability, in the project. Needless to say, however, we became aware of the cost containment issues in North Carolina's Medicaid program. As a result, in this report we occasionally volunteer cost containment recommendations.

I. INTRODUCTION

The North Carolina General Assembly commissioned this study to evaluate the policies that determine the amount, sufficiency, duration, and scope of services provided under North Carolina Medicaid, determine which are still relevant and effective, and suggest changes to those that are less effective in helping the state achieve its policy goals. This report provides information to facilitate future decision-making by the General Assembly, including specific recommendations that demonstrate how the program can be modified to continue to meet the needs of Medicaid beneficiaries in an era of significant budgetary pressure to contain costs.

A. Medicaid Programs Try to Balance Access and Cost Containment Goals

Broad federal guidelines allow each state to determine the "amount, duration and scope" of services offered by Medicaid, as long as each service is "sufficient... to reasonably achieve its purpose." States are also allowed to place appropriate limits on a Medicaid service based on medical necessity and utilization control.

Under these federal guidelines, state Medicaid programs confront a fundamental tension: on the one hand, how to design an appropriate benefit package for the poorest and most disabled members of our communities and ensure access to Medicaid services while, on the other hand, meeting cost containment and program integrity goals. Consider the following diagram (Exhibit I-1). In it, a beneficiary's medical need for a service is defined to be an objective test. When access and cost containment are roughly equal, the extent of Type I and Type II errors is the same.

Exhibit I-1. Neutral Policy

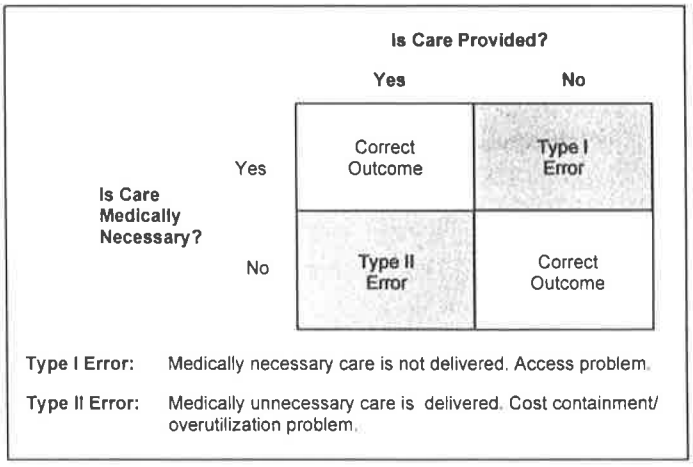
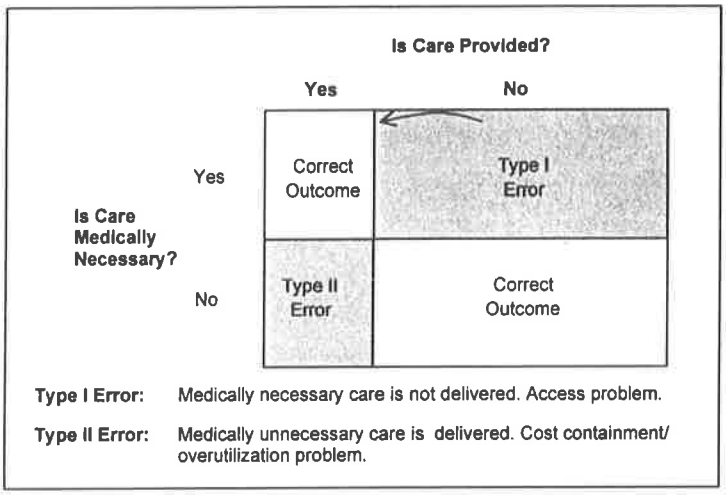


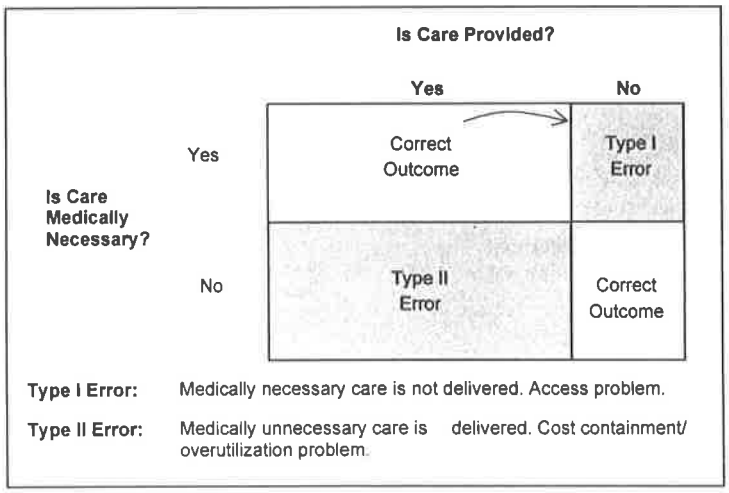
Exhibit I-2 shows that when states crudely emphasize cost containment through strict utilization management rules, lower provider fees, and/or bare bones benefit packages, they reduce their Type II overpayment errors but increase their Type I access-problem errors.

Exhibit I-2. Crude Cost Containment Emphasis



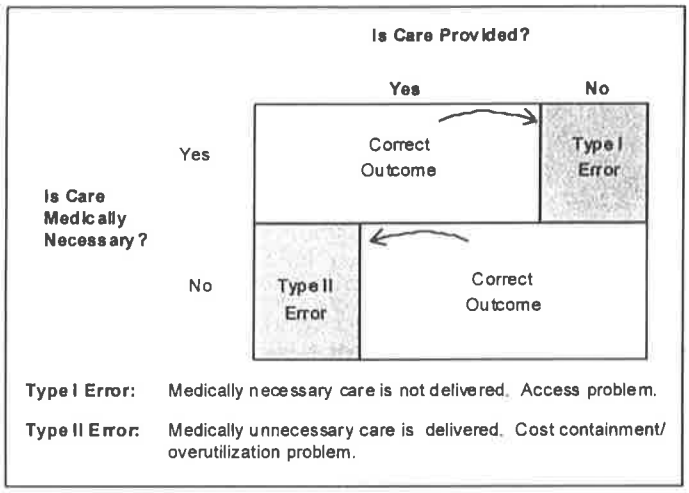
Now consider Exhibit I-3. It crudely emphasizes access over cost containment by eliminating meaningful utilization review, adding benefits to the Medicaid package without data demonstrating their value, and/or raising provider fees to create incentives to deliver benefits where they may not be necessary. These approaches decrease Type I access problems, but increase Type II (cost containment) errors.

Exhibit I-3. Crude Access Emphasis



Finally, consider Exhibit I-4. It simultaneously seeks to emphasize access and cost containment objectives. To achieve this balance a Medicaid program needs to have a good utilization management process (to provide care where it's necessary and prevent care where it's not), it should add benefits only when supported by data, and the Medicaid program should adopt a nuanced provider fee schedule to pay enough for access (on a benefit-by-benefit basis), but not so much that unnecessary care is encouraged.

Exhibit I-4. Balance



B. DMA's Focus on Access Drives Many Decisions

The Division of Medical Assistance (DMA) is part of the Department of Health and Human Services, which is the single state Medicaid agency responsible for developing and implementing Medicaid policy. In discussing DMA's approach to designing the state's Medicaid benefits with agency staff, several common themes emerged. We identified several "core philosophical principles" that are not formally stated in agency policy but nevertheless guide many of DMA's decisions. These principles routinely lead to, and indeed are intended to lead to, broad access to a full array of Medicaid benefits. Absent vigilance, DMA's philosophy to promote access can lead to the results in Exhibit I-1.

The core principles include:

- Promoting beneficiary access to needed services as the highest value, even where such access may lead to expenditure increases;
- Promoting maximum provider participation in Medicaid by, for example, requesting the General Assembly to provide funding for Medicaid reimbursement rates to physicians that are higher than neighboring states and remain higher than average without discernible benefits;
- Implementing minimal utilization review requirements, in keeping with the state's desire to "trust" its providers; and
- Maximizing federal financial participation ("FFP" or federal "match" for state dollars spent) to public sector providers of care, by encouraging the identification of as many state services that are eligible for adoption in the Medicaid state plan as possible.

These principles are laudable, and plainly serve the beneficiaries. However, they can result in overpayments and unnecessary expenditures when not complemented by the tools needed to

strike the balance described in Exhibit I-4: firm utilization management, targeted provider fees and data-driven benefit decisions.

In many other states, more emphasis is placed on crude cost containment, as shown in Exhibit I-2. The approach in these states is not to enroll all providers, but only those providers necessary to deliver the benefits. For example, in most states the Medicaid reimbursement rates to physicians are set far below the rates paid in North Carolina. This may lead to reduced provider participation in Medicaid (and therefore potential access problems – a Type I error), but greater cost containment. Also, in many other states the scope of the Medicaid benefit package is not as extensive.

DMA told us that these decisions made by many of its peer Medicaid agencies around the country inappropriately clamp down too much on access in a way that reinforces the "Medicaid stigma." In following the core principles outlined above, North Carolina has successfully avoided many of the access problems faced by other states. DMA is rightfully proud of its record in emphasizing Medicaid beneficiary access to care. For example, DMA has been able to achieve very high rates of provider participation, helping "mainstream" Medicaid beneficiaries by allowing them to see the same doctors as other people in their communities and avoiding the "Medicaid mill" type of care beneficiaries in some other states are forced to rely on. North Carolina's broad benefits package also allows many of the state's most vulnerable beneficiaries—those who would typically be placed in long term care facilities—to receive the services they need outside of an institution and remain in their homes and communities. North Carolina is ahead of most other states in offering eligibility to the aged, blind, and disabled up to 100 percent of the federal poverty level. But the downside is just as apparent: the difficulty DMA has containing costs.

C. Cost Containment Goals Can be Achieved without Jeopardizing Access

This study has found that while the decisions based on these core principles are rational decisions and have enabled the state to achieve its access goals, some of these decisions have had unintended consequences—the Type II overutilization and program integrity problems discussed in the first section of this chapter. Exhibit I-5 shows an example that will be discussed in depth in this report of how a current North Carolina benefit policy results in unintended consequences, and how a more balanced approach to that same policy goal might be structured.

Exhibit I-5. Unintended Consequences of Current Access Approach

Policy Goal	Current Approach	Unintended Consequences	Balanced Approach to Reach Same Goal
Promote client access to state-of-the-art medications	Remove barriers to care such as prior authorization and utilization review	Some beneficiaries may be receiving brand-name drugs for conditions that could be treated just as well with cheaper generic drugs, or are receiving duplicative drugs that could have been identified during prior authorization review	Require prior authorization for drugs prone to misuse but allow open access to other brand-name and generic drugs

This alternative approach, an example of the diagram in Exhibit I-4, would allow DMA to continue to promote its goal of broad access for Medicaid beneficiaries while ensuring that care is delivered in a medically appropriate, cost-effective manner. We found that this balance exists in several benefits, notably inpatient hospital and nursing home benefits. It does not exist in others, most prominently prescription drugs and in the overly generous reimbursement rates paid to physicians. This report is intended to identify the areas throughout the North Carolina Medicaid program where changes can be implemented to correct some unintended consequences and errors—improving program integrity and cost containment -- while preserving access to appropriate care.

D. Overview of Remaining Chapters

Chapter II of this report contains an evaluation of current Medicaid policies and procedures to identify what DMA is doing well and should build on, and where DMA faces challenges and could improve. Chapter III summarizes our clinical and operational assessment of several key Medicaid benefits, including pharmacy, long-term care, and community-care services. Recognizing that many of the challenges facing DMA are not unique to North Carolina—or even to Medicaid—Chapter IV presents alternative approaches from several other Medicaid programs, and from private insurers in North Carolina.

Chapter V demonstrates how North Carolina can modify its Medicaid program to correct the "Type II errors" identified in Chapter II. Section V.A shows that access and cost containment goals can be balanced without negatively affecting beneficiaries. Section V.B discusses the operational changes and resources that could be infused into DMA to strengthen program integrity and more closely manage utilization and costs. Section V.C summarizes the potential cost savings that might be realized through these changes. Chapter VI concludes our study.

Several appendices are included in a separate volume. Appendix A provides detailed comments on specific Medicaid benefits. Appendices B and C summarize our findings and recommendations, respectively. The remaining appendices provide additional information to support or expand upon points made in the text.

The findings and recommendations presented in this report are based on an extensive review conducted between December 2000 and April 2001 by The Lewin Group and the West Virginia Medical Institute. The Lewin Group, based in Falls Church, Virginia, has consulted on health policy issues for more than 30 years. The Lewin Group staff dedicated to this project has extensive experience in Medicaid operations, program evaluation, and technical and analytic consulting. In addition to this broad experience in Medicaid program operations, The Lewin Group consultants have substantial expertise in several areas that are strong drivers of increasing Medicaid costs in North Carolina, including long-term care, services for persons with physical and mental disabilities, and pharmaceuticals. The Lewin Group project team drew on its experience working with more than a dozen state Medicaid programs on a host of operational issues to inform this study.

The West Virginia Medical Institute (WVMI) is a Medicare-approved Peer Review Organization with more than 20 years of experience conducting utilization review for multiple state Medicaid programs. WVMI employs a large team of clinical specialists, including board-certified

physicians in a range of specialties, experienced nurse practitioners, and registered pharmacists. WVMI staff have conducted research into Medicaid coverage and criteria for behavioral health services, case management, organ transplants, 24-hour nursing, durable medical equipment and other services in a number of states, and have assisted Virginia and West Virginia in developing Medicaid coverage policies and criteria for new services and revising criteria for existing services. The WVMI medical staff dedicated to this project applied their detailed knowledge of Medicaid benefits and utilization review to assess the clinical appropriateness of North Carolina's Medicaid benefit policies and approaches towards utilization management, service definition, medical necessity criteria, cost containment and program integrity. Their evaluation is also informed by the experience of several project team members in commercial insurance operations and clinical practice.

As consultants to the General Assembly, The Lewin Group and WVMI were charged with reviewing the Medicaid coverage policy development process to understand the theory behind the composition and administration of the state's benefits and to inform this investigation of the appropriateness of the benefit package and evaluation of how beneficiaries access those benefits. Consultants also examined utilization review contracts, provider education materials and billing instructions, waiver program documentation, memoranda of understanding with other state agencies, and other documents related to the development and implementation of Medicaid coverage policy.

The project team then reviewed the individual Medicaid service definitions and utilization management criteria for the complete range of Medicaid benefits to assess their clinical appropriateness. Consultants investigated the capabilities of the state's claims processing system and other system supports designed to ensure that each benefit is provided as described in the service definitions. Data analysts examined claims and budget information to assess the effectiveness of coverage policies and implementation procedures.

The Lewin Group and WVMI consultants conducted interviews with 34 individuals representing multiple levels of DMA and all Medicaid benefit areas, including: DMA assistant directors in other units affecting Medicaid policy (e.g., Financial Operations, Managed Care, Program Integrity); all of the Medicaid contractors responsible for reviewing and approving benefits and paying claims; and staff at other state agencies that influence or manage portions of the Medicaid benefit (e.g., Division of Mental Health, Developmental Disabilities, and Substance Abuse). Consultants also interviewed state staff and reviewed Medicaid program materials from 10 states, and spoke with staff at four large North Carolina insurers. An interview list is included in Appendix D.

II. BENEFITS DESIGN AND MANAGEMENT

The focus of Chapter II is a review of North Carolina's Medicaid benefit policies. This chapter includes a summary of the process by which the benefit package is designed, how it is influenced, and how these benefits are managed, taking into account utilization review techniques and other features that affect access.

A. The Process for Developing Medicaid Policies

1. General approach emphasizes access

As noted in the Introduction, DMA's approach toward Medicaid benefits emphasizes access. This emphasis is reflected in the:

- Broad interpretation of the amount, scope, and duration of mandatory Medicaid services;
- Inclusion of many state-provided services in the Medicaid benefit package; and
- Provider reimbursement rates that are on a par with Medicare and other payers.

a) Broad "amount, scope, and duration" of services

In order to receive federal matching funds, certain basic services such as hospital services, physician services, lab and x-ray, nursing facility services for adults, screening, diagnosis and treatment services for children, and family planning services must be offered by a state Medicaid program. Within the broad scope of services mandated by the federal government, states are generally free to determine the amount, duration and scope of these services, provided they are sufficient to achieve their objectives.

North Carolina often utilizes a broader definition of the amount, duration, and scope of a benefit than required by federal law. For example, state Medicaid programs are required to provide home health care for persons eligible for nursing facility services. North Carolina has chosen to provide home health care not only for this group of persons, but also for any Medicaid beneficiary with a medical reason indicating why the services should be provided in the person's home instead of in a physician's office, clinic, or other outpatient setting.

Similarly, like many states, North Carolina has chosen to include a "therapeutic leave" option as part of its nursing facility and adult care home coverage. This policy, which is not part of the mandatory nursing facility benefit, allows a facility resident to temporarily leave the nursing home or adult care home and return to the community (e.g., go to a relative's home for the holidays). The state "holds" the bed by continuing to pay the facility as if the patient were still there. While a therapeutic leave policy is common in state Medicaid programs, North Carolina permits therapeutic leave of up to 60 days per year, which is quite generous compared to other states' limits of 10 to 15 days per year.

The liberal home health definition and the generous therapeutic leave option are well-motivated policies intended to help North Carolina Medicaid beneficiaries access services in the most appropriate setting or leave a facility for a short period with the security of knowing that they can return. Both policies reflect DMA's compassion for Medicaid beneficiaries. They are also

examples of how different interpretations of "amount, duration and scope" of benefits can lead to very dissimilar Medicaid programs across the 50 states, with very different expenditure patterns.

The range of services North Carolina covers is also indicative of DMA's philosophy of maximizing coverage of health care services for Medicaid beneficiaries. North Carolina covers 27 of the 34 services that are optional for state Medicaid programs. These optional services include intermediate care facilities for the mentally retarded (ICF/MR), personal care services in private residences, prescription drugs, dental services, vision services, adult health screening, chiropractors, podiatrists, hospice, private duty nursing, transportation, and case management services (a complete list can be found in Appendix E). While many of these 27 "optional" services are essential health care benefits covered by most, if not all state Medicaid programs (e.g., prescription drugs, ICF/MRs, nursing facilities for children), only 16 other states cover as many optional services as North Carolina.

Recommendation

✓ Re-evaluate whether to cover benefits not offered by the majority of other state Medicaid programs.

b) Inclusion of state-provided services in the benefit package

As in many other states, North Carolina public agencies are direct providers of Medicaid services:

- The Division of Mental Health, Developmental Disability, and Substance Abuse Services provides mental health services through Area Mental Health Authorities;
- The Division of Public Health provides many primary care services and performs health testing through local health departments; and
- Local education agencies provide speech, language, and physical therapy to special needs students in their schools.

In the absence of Medicaid, North Carolina would pay for many of these services with state-only funds. Thus, for those mental health, public health, and school-based services that can be covered by Medicaid, it is often to the state's fiscal advantage to do so because the federal government will pick up a portion of the cost. In state Fiscal Year 2002, for every $1.00 spent on Medicaid services, North Carolina will receive approximately $0.62 from the federal government (see Exhibit II-1). The federal government will also pay half or more of the administrative costs associated with operating the Medicaid program. Therefore, providing these services through the Medicaid program brings federal money into the state both as reimbursement for services provided by state and local government agencies and as a contribution towards these agencies' overhead and administrative staff costs.

Recommendation

✓ Do not add benefits simply to maximize federal funds to governmental providers. Only add these benefits when clinical data suggests improvements in health care.

Exhibit II-1. State/Federal Contributions

Medicaid service expenditures are divided between the federal government, state government, and counties, as follows:	SFY 2002
Federal government	61.71%
State	32.54%
Counties	5.75%
The federal government pays different proportions for family planning services and administrative spending:	
Family planning	90.0%
General administration	50.0%
Information systems and skilled medical staff	75.0%

DMA has an incentive to maximize access to public providers in order to maximize the amount of federal matching funds that it receives: Medicaid revenues can be used to subsidize the cost of caring for other state residents, such as the uninsured, typically served by these providers. This provides an important explanation for the reason that many state Medicaid benefit packages are more extensive than private insurers' benefit packages: these benefits are expressly intended to provide federal financial support to public "safety net" providers (e.g., community mental health centers, county health departments, public schools, county hospitals). While it is important to offset state expenditures to the extent possible with federal funds, however, it is equally important that these incentives not outweigh other factors that should affect access to care, such as medical necessity and program integrity. Services delivered by public-sector providers should be managed effectively and with discipline, as should services delivered by private-sector providers.

c) Provider reimbursement rates

A state has a great deal of freedom to determine the reimbursement rates it will pay for Medicaid services. There are few federal upper-end limits or caps. At the lower end, the federal government requires that "reimbursement rates must be sufficient to enlist enough providers so that Medicaid 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 that geographic area."

Many states interpret this requirement to mean that rates must be sufficient to attract enough providers to the Medicaid program to provide the range of Medicaid-covered services. Consequently, many states pay Medicaid providers very little compared to the rates paid by Medicare or private insurers. The federal government has not challenged this assumption.

North Carolina, however, takes this requirement very literally; DMA budget staff stated their belief that the Medicaid program must "have a reimbursement rate that assures access at the same level of a person not covered by Medicaid." Beginning January 1, 2000, physician rates for Medicaid services increased from 91 percent of Medicare rates to 100 percent of Medicare rates. This action was intended to promote access by encouraging physician participation in Medicaid equivalent to their participation in Medicare.

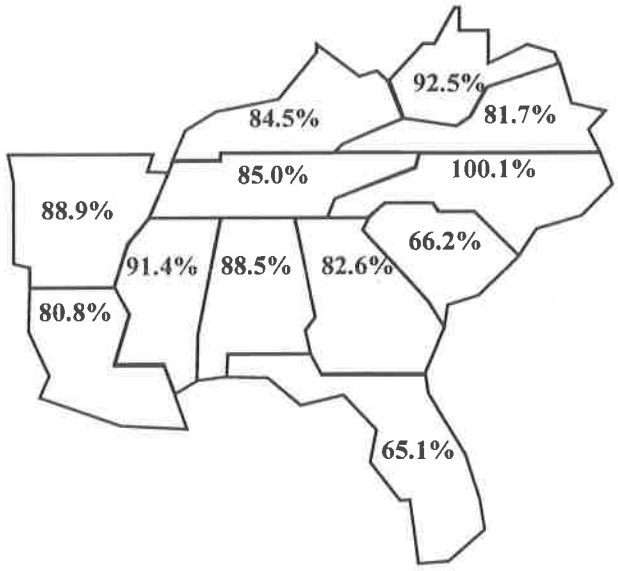
It appears, however, that this substantial increase was not necessary because some types of providers for whom rates were raised already had very high participation in Medicaid at the lower reimbursement rate. For example, more than 95 percent of primary care providers participated in Medicaid before the January 2000 fee increase, due in part to the extra $2.50-3.00

per enrollee per month paid to primary care providers who serve as primary care case managers for Medicaid under Carolina ACCESS.[1]

This increase also put North Carolina among the highest-paying states for physician services (see Appendix F for more detail). Even at the earlier 91 percent of Medicare rate, North Carolina paid providers more than any adjacent state, none of which pays more than 85 percent of Medicare allowable fees, as shown in Exhibit II-2.

Exhibit II-2. Comparison of Medicaid Payment Rates

North Carolina pays its Medicaid providers a higher percentage of Medicare fees than any other state in the region.



Source: "Comparison of Physician and Dental Fees Paid by State Medicaid Programs," Medi-Cal Policy Institute, 2001.

Given the high rates of physician participation *prior* to the January 1, 2000 increase, it is reasonable to assume that the state could lower physician fees back to the pre-2000 level of 91 percent of Medicare and continue to maintain access near current levels. This could achieve some amount of cost savings for the state, as physician fees account for nearly 10 percent of spending on Medicaid services. For each percentage point reduction in the Medicaid fees, the program would save $5.65 million in total dollars, or $1.84 million in state funds. Thus, reverting back to 91 percent of Medicare would save $50.9 million in total funds ($16.5 million state

[1] The care management fee is $3 per member per month for the first 250 Medicaid beneficiaries enrolled with a given primary care provider; the provider is paid $2.50 per member per month for any additional enrollees. See Appendix G for more information.

dollars) without harming access. A reduction to 85 percent of Medicare – equal to the highest neighboring state of Tennessee – would save $84.75 million total dollars ($27.6 million state funds), although the affect it would have on access is unknown. Exhibit II-3 shows the reimbursement impact of the reduction from 100 percent to 91 percent of Medicare rates on certain common Medicaid services.

There are several approaches DMA can use to mitigate the impact a physician fee decrease might have on physician participation and therefore access. For example, DMA already structures some policies to retain providers in Medicaid by keeping administrative requirements to a minimum and paying claims as fast as or faster than other North Carolina insurers. These policies encourage physicians to participate in Medicaid despite lower reimbursement rates, because the cost to the physician of complying with administrative requirements and collecting payment is lower than it might be with other payers.

In addition, physicians in many of the primary care specialties (e.g., internists, family practitioners, OB/GYNs) can participate in the Carolina ACCESS primary care case management program and receive $2.50 to $3.00 per month for each Medicaid beneficiary they agree to "manage" (see Appendix G for more detail). These case management fees offset to some degree the lower Medicaid provider reiumbursement rates, which has probably contributed to the high rate of Medicaid participation among primary care providers.

DMA can also structure physician reimbursement rates to attract and retain physicians in the various specialties according to those providers' historical participation rates. For example, most North Carolina pediatricians participate in Medicaid, in part because a substantial percentage of children in the state are covered by Medicaid. Reducing the fees paid to pediatricians would probably not have a significant negative impact on access.

DMA is justifiably proud of the high provider participation and satisfaction levels in its Medicaid program, and can maintain these achievements, as well as access to physicians for beneficiaries, while paying less.

Recommendation

- ✓ Reduce Medicaid physician fees to 91% of Medicare rates
- ✓ Evaluate whether access would be comprised by a further reduction to 85% of Medicare – equal to the highest neighboring state

2. *DMA's internal policy process is changing*

DMA consists of several units that deal with specific Medicaid program functions and/or specific Medicaid program benefits. The Medical Policy Unit (MPU) is responsible for developing coverage policies (e.g., scope, amount, duration, and utilization management procedures) for the diverse array of services, procedures, and supplies covered by the Medicaid program. The MPU is divided into several sections representing related groups of benefits (note that the list below is not exhaustive):

- *Behavioral Health Section:* inpatient and outpatient psychiatric services, intermediate care facilities for the mentally retarded, substance abuse treatment;

- *Institutional Care Section:* inpatient and outpatient hospital services, skilled nursing facilities, nursing homes, adult care homes;

- *Practitioner and Clinic Services Section:* primary care and specialist physicians, health department services, lab and x-ray; and

- *Community Care Section:* home health, private duty nursing, personal care services, hospice.

Some benefits, such as optical services, dental care, pharmacy, durable medical equipment, and school-based services are administered by individual benefit directors in the MPU. The primary communication link between all of these sections resides at the section chief level, with the Assistant Director of the Medical Policy Unit providing oversight and coordination on policy issues.

Coverage policies address both what is covered (e.g., what specific surgeries are allowed under the hospital benefit) and how the benefit is managed (e.g., do beneficiaries have to get permission to obtain the service or is it open-access). "What is covered" is usually defined by the scope, amount, and duration of services allowed, and to some extent, who is eligible for the service. For example, the personal care services (PCS) benefit is defined as:

> "tasks corresponding to In-Home Aide Level II and Level III-Personal Care in DHR's In-Home Aide Services Plan. PCS for women in the Pregnant Women eligibility category must be related to the pregnancy. The amount of PCS covered for a patient in a calendar month is up to a maximum of 80 hours total time for the month."

The management of individual benefits is generally referred to as "utilization management." *Utilization management procedures (see Exhibit II-4) have as great an effect on access and cost as the amount, scope, and duration limitations on each benefit.*

Until recently, each MPU section used its own process for making coverage policy decisions and recommendations. These separate processes, though largely similar, differed in some ways, such as how new policy requests were initiated, the type and amount of research used to evaluate the proposed policy change, how the services and criteria were defined, and how policy changes were tracked from inception to completion. This decentralized approach toward policy-making has led in the past to inconsistencies in the Medicaid benefit package, particularly in how benefits are delivered.

Exhibit II-4. Utilization Management Procedures

"Utilization management" refers to the process of evaluating patient need for a given service on a case-by-case basis to ensure that only the medically appropriate amount, duration, and scope of services are provided. Utilization management involves systematic comparison of a patient's needs as described by a medical provider to defined clinical criteria.

Utilization management prevents the delivery of unnecessary services, helping to contain costs and maintain program integrity. If the criteria are too strict or applied inconsistently, the utilization management process may inhibit access to care.

Prior authorization is a front-end utilization management tool that requires patients and/or their providers to obtain permission for a service before it is delivered. Prior authorization prevents the utilization of unnecessary or inappropriate services.

Retrospective review is a back-end tool that compares services already delivered to clinical criteria to determine if they were justified. Retrospective review allows the payer (in this case, Medicaid) to identify and recoup inappropriate payments.

For example, the Community Care Section has close working relationships with the main providers of community care services (e.g., home health agencies, nursing agencies) and their respective provider associations. Providers suggest many of the policy changes considered by this section, and their input is actively solicited during the policy development process. Community Care policies are very provider-oriented: service definitions are broad, and utilization controls are limited. This is not necessarily a weakness—provider cooperation and understanding of the benefits are essential aspects of ensuring that they are delivered appropriately. However, this approach, which is intended to promote access through provider participation, may err too far on the side of access over cost containment, leading to the results in Exhibit I-2 in the Introduction.

Another example of how devolution of responsibility to individual benefit managers can lead to problems is evident in the pharmacy program. The pharmacy benefit director's opinion is that prior authorization for prescription drugs is not cost-effective and therefore he does not conduct, as some other sections do, analyses to determine if certain new drugs should be subject to utilization review. As explained in further detail in Chapter III, the relatively hands-off approach towards pharmacy benefit management has resulted in escalating drug expenditures -- even when compared to increases in other programs' drug costs -- and potentially unnecessary utilization.

Recognizing the need for a more standardized, centralized process, the Assistant Director of the MPU recently implemented a formal policy development process. This process encourages all sections to consider the same array of issues (e.g., financial impact, best practices from medical literature, methods employed by other state Medicaid programs and private insurers) when defining Medicaid policies. Furthermore, the process provides for documentation of which individuals within DMA provided input, what data were examined, and the current status of the policy request.

Recommendation

✓ Continue to emphasize a more uniform approach to benefit evaluation

The MPU began using this standardized process on March 1, 2001. At this early stage, our study could not capture any effects attributable to the new process. However, our review of the process indicates that it may help ensure that access and cost containment/program integrity issues are given more equal consideration during the policy evaluation process, and that this might help future policies reflect a more appropriate balance between these program goals.

3. Policymaking process involves multiple stakeholders

Medicaid policies cannot be made in a vacuum—to be effective, they must incorporate and address input from the other organizations responsible for implementing, providing, paying for, and monitoring the policies. These stakeholders include the other units within the Division of Medical Assistance, other state agencies under DMA's parent, the Department of Health and Human Services (DHHS), and numerous external stakeholders such as beneficiaries, providers, legislators, and taxpayers. The challenge to DMA is to process multiple, often competing or contradictory points of view, in designing benefits.

a) Other DMA units

Other DMA units besides Medical Policy play roles in coverage policy development. The Fiscal Unit sets reimbursement rates for all services, which strongly influences provider interest in delivering services and consequently affects access to and usage of the service. The Program Integrity Unit, which is charged with monitoring potential fraud and abuse, is often the first source of information on how benefit policy designs or definitions have led to overutilization or abuse. The Managed Care Unit administers the Medicaid managed care programs (such as Carolina ACCESS) that significantly affect how Medicaid benefits are delivered for nearly three-quarters of the Medicaid population (see Appendix G for information on Medicaid managed care).

There are both formal and informal channels of communication between these units and the Medical Policy Unit. For example, the Fiscal Unit provides cost projections for proposed policy changes and must sign off on any final policy proposal. The Program Integrity Unit provides expertise in structuring policies so that they will be easier to enforce and less prone to fraud and abuse. The Assistant Directors in charge of each of these units meet regularly to approve policy changes and prioritize policy implementation processes. Successful benefit policy-making depends on all of these units working closely together.

Recommendation

✓ Continue to ensure that input from other DMA units is appropriately communicated to the Medical Policy Unit benefit managers

b) Sister agencies

As discussed earlier, North Carolina maximizes federal contributions by using Medicaid to pay for services provided by other public agencies, such as the Division of Mental Health, Developmental Disability, and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). North Carolina delegates some administrative responsibilities to the agencies that provide these services. DMA closely involves DMH/DD/SAS, the Division of

Public Health, and the Office of Research, Demonstration, and Rural Health Development (ORDRHD), which co-administers the Carolina ACCESS program, in Medicaid policy discussions. In fact, all Medicaid behavioral health policy is developed collaboratively by DMH/DD/SAS and DMA.

Because a portion of the sister agencies' budgets are dependent on Medicaid and because these agencies also serve as advocates for their constituencies, they seek to influence Medicaid policy (e.g., what benefits are covered, how those benefits are implemented). For example, given that one role of the Division of Mental Health is to serve as an advocate for the state's mentally ill and developmentally disabled citizens, DMH/DD/SAS policy suggestions tend to promote broad access to behavioral health services. While it is entirely appropriate for DMH/DD/SAS to advocate these positions, a problem may occur if policy recommendations advocating broad access are not counterbalanced by an emphasis on program integrity and cost containment. Going back to the illustrations in the Introduction, this is precisely the difference between Exhibits I-2 and I-4. DMA is responsible for controlling utilization, containing costs, and maintaining the integrity of the Medicaid program. While the input of sister agencies, particularly those that administer Medicaid benefits, is important, it should be adequately tempered by other authority resting within DMA.

c) External stakeholders

Medicaid—like other publicly-funded social services programs—is also accountable by law or custom to a wide variety of external stakeholders, as shown in Exhibit II-5 below.

Exhibit II-5. External Influences on Medicaid Policy

Government	Other Stakeholders
• Federal law and regulation	• Beneficiaries
• State legislators	• Advocates
• Governor and executive branch	• Providers
• Courts	• Health care trade associations
• Counties	• Taxpayers

The new standardized process for policy development includes steps to identify and evaluate input from these external sources.

4. Policy process improvements can be made

DMA can continue to strengthen the integrity of the policy development process by improving three aspects of the process:

- Increasing usage of internal feedback in forecasting the impact of new policies and revising existing policies;
- Using more clinically-based evidence in defining benefit coverage and limitations; and
- Ensuring that policies can be enforced through front-end or back-end monitoring procedures.

a) Feedback loop

The Assistant Director for Medical Policy notes a disconnect between "expectations" and "operational reality." The intended effects of a given benefit policy change are not always achieved, and unintended consequences are sometimes felt. He attributes some of the failure to properly anticipate effects to the lack of a consistent process for evaluating the impact of policy changes after the change has been made. Without this information, it is difficult for policy-makers to apply the "lessons learned" from former policy decisions to new issues.

The current feedback process used by the MPU is informal and varies from section to section. Some sections dedicate resources to reviewing existing policies. For example, Institutional Services works to continually refine and improve its utilization management approach, as shown in Exhibit II-6. As discussed later in this chapter, Institutional Services is in the process of updating its entire approach towards managing the nursing home benefit, with the overall goal of improving the quality and appropriateness of care and utilizing limited resources wisely. However, some sections do not closely review utilization reports or track changes in benefit delivery to identify potential problems or ensure that new policies are having the intended effects.

Exhibit II-6. Use of Feedback in Updating Medicaid Policy

Medical Review of North Carolina (MRNC), under contract with DMA, examines the appropriateness of level of care changes in nursing facilities. Originally, MRNC reviewed only 500 records each month. These reviews revealed that a significant proportion of level of care changes were inappropriate. The Institutional Services section chief then doubled the size of the sample to identify more problems and send a stronger message to providers that they were being closely monitored.

Feedback from other DMA units is also handled informally. For example, the Program Integrity Unit is often the first organization to identify unintended consequences of policy changes, because it is responsible for systematically reviewing service delivery to detect patterns of fraud and abuse. A periodic review might identify much higher utilization of a given service than was projected based on expected medical need, indicating that the policy might be defined too loosely or that the estimate was inaccurate. Although Program Integrity staff frequently communicate these findings to MPU, there is no systematic process for ensuring that the feedback is recorded, evaluated, and acted upon in a timely manner. Improving this feedback loop could substantially improve program integrity by identifying and closing loopholes,

Recommendation
✓ Consistently evaluate the actual utilization trends, health outcomes and data on new services 12-18 months after implementation

understanding what types of policies are particularly prone to abuse and overutilization, and ensuring that policies can be enforced.

Accurate forecasts of the expected costs and utilization of proposed benefits are critical. Cost information is needed to determine if the benefit is cost-effective and whether it is affordable within the constraints of the Medicaid budget. Utilization information is a factor in cost projections and can also be used to evaluate whether a proposed benefit will sufficiently address the need it is expected to fill. It is crucial to take into account potential changes in behavior that might result from the changed policy because projections may otherwise significantly under- or over-estimate the actual impacts on cost and access (utilization). While estimating behavioral changes can be complex, DMA has extensive information on the cost and utilization impacts of previous coverage decisions, and can compare these results to the projections made before these decisions were approved to determine what, if any, unexpected changes in utilization might occur.

Recommendation

✓ Compare information on the projected utilization and actual utilization of existing benefits to refine beneficiary and provider behavioral modeling techniques and refine future forecasts

Routinely using an evaluation process after a new benefit is defined would have another beneficial effect. It would discourage DMA staff members from using "best case" assumptions in their modeling of prospective changes, if they were tempted to do so, because they would know that these assumptions eventually will be compared to actual utilization.

b) Clinical basis for coverage policies

Since March 1, 1990, DMA has used a definition of medical necessity for most services that is premised on "generally accepted North Carolina community practice standards" (see Exhibit II-7). In other words, DMA determines whether care is medically necessary based on the practice patterns of local providers or the coverage criteria of other health plans in the state.

Exhibit II-7 North Carolina Medicaid Medical Necessity Definition

"All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

10 NCAC 26C, 0105 MEDICAL SERVICES Effective March 1, 1990.

According to the State Medicaid Director, DMA adopted this definition of medical necessity at the recommendation of the State Attorney General's office. At the time, it was believed that a community standard of care would enable the state to pursue cases of fraud and abuse by presenting evidence that the provider(s) in question were not adhering to medical practices in accordance with the patterns in their communities. This definition of medical necessity has, however, allowed providers to have considerable input into coverage decisions, creating potential conflicts of interest.

While community-based standards of care were more common in the 1980s, they have since been replaced in the medical field by nationwide practice guidelines established by provider organizations (such as the American Academy of Pediatrics) or as proven in peer-reviewed medical journals. Chapter IV discusses how several North Carolina private insurers determine the clinical basis for medical policies and define medical necessity in ways that could be adopted by North Carolina Medicaid.

Recommendation

✓ Adopt a definition of "medically necessary" that is consistent with current references to national standards of care

c) *Enforcement of Medicaid policies*

In general, the Medicaid claims processing system is able to enforce benefit policies when the appropriate eligibility groups, provider types, and specific procedure codes are clearly identified during the policy development process. DMA and EDS, the fiscal agent/claims processor, employ a rigorous design process. This process examines the system's numerous reference tables, multiple inputs from other state agency information systems, contractors, and data vendors, and existing sets of edits and audits to determine the coding and programming changes needed to comply with new or revised policies.

Despite these efforts, weaknesses appear in situations where the underlying policies cannot be enforced through the claims payment system (e.g., information needed to limit utilization is unavailable on claim forms) or where significant coordination is required among providers and case managers to enforce service utilization. For example:

- Policies that restrict service utilization by the time of day cannot be enforced because the Medicaid claim form does not track the actual time the service was rendered. Moreover, since information about the time of day is not available, Program Integrity cannot undertake retrospective reviews and recoup funds when appropriate.

- Medicaid policy requires that providers adhere to the service limits noted in a CAP beneficiary's plan of care, which is developed by the beneficiary's case manager. In addition, providers are to have their claims approved by the case manager prior to submitting them to the fiscal agent for reimbursement. The service limits in the beneficiary's plan of care cannot be enforced through the fiscal agent system because EDS cannot compare a beneficiary's actual utilization with the services that have been authorized. In addition, there is no audit that checks for the case manager's approval of the claim.

In cases such as these, where there are policy justifications for defining service limitations in a certain way that cannot be enforced by the claims payment system, DMA should provide alternative mechanisms for reviewing utilization and provider behavior to ensure that policies are being followed. Alternative mechanisms may also be appropriate in circumstances in which the amount of potential overspending or abuse is likely to be less than the cost of reconfiguring the claims processing system. These mechanisms can include staff in the Medical Policy Unit responsible for overseeing certain benefits, such as the Community Care section, and staff in the

Program Integrity that have full-time responsibility for reviewing and investigating service provision patterns.

DMA estimates that the addition of two home care nurse reviewers in the Community Care section, at a total cost of approximately $90,000 a year, could save up to $500,000 a year by performing more oversight of the kinds of services listed in the two examples above. In addition, the Program Integrity Unit has made many investments in developing automated tools that can identify more areas for review than current staff can handle. DMA estimates that the addition of five medical review nurses, four investigators, and a clerical support person at a cost of approximately $462,000 per year could result in $1,500,000 in annual savings through cost avoidance and recoupment of inappropriate payments. We believe these estimates are reasonable, and would address the problems described above.

In addition to the system coding problems, the process for entering new policies into the system also has flaws that can result in overutilization or compromises to program integrity. For example, the start date for a policy (as noted in Medicaid provider bulletins) is often independent of the completion of necessary updates in the claims processing system. Since the policy exists only on paper, DMA trusts that providers will carefully review program bulletins and change their practices as needed to avoid inappropriate provision of services. However, there are at least two examples of services that were provided in violation of a new policy because providers were either unaware of or ignored the change, and the system was not ready to block payment:

- In 1996, DMA expanded adult care home services to include basic and enhanced levels of care. However, for a span of 18 months there was no system audit that checked the billing rate against the beneficiary's level of care eligibility. According to DMA, this oversight resulted in $900,000 in overpayments to adult care homes, of which DMA expects to recoup $767,000.

- All prescriptions for Viagra are supposed to receive prior approval from the DMA Pharmacy Director. For the first two months after coverage for Viagra went into effect, though, the automated edits that were needed to check for the prior authorization number were still under development. As a result, claims were paid for excessive amounts of Viagra—some patients received dozens of pills at a time—because the system could not distinguish between approved and non-approved prescriptions. DMA reported to us that the amount of funds involved was only $23,000.

Recommendation

✓ Formally include in the policy development process an evaluation of whether the claims payment system will enforce the benefit policy or whether another strategy (post payment review, medical record review, etc.) will enforce the benefit policy

✓ Do not implement a new benefit until either the system is ready or the alternative enforcement mechanism is in place

The examples above show that properly configuring the claims processing system is crucial to enforcing the amount, duration, and scope of benefits as originally intended and written into policy. Programming errors or

oversights can have important implications for Medicaid spending and patient access. DMA should strengthen the process for implementing system edits and structuring policies in such a way that they can be enforced by the claims system or, if that is not a cost-effective strategy, an alternative strategy is in place.

B. The Process of Managing Medicaid Benefits and Program Integrity

1. Utilization management functions are divided

Utilization management activities—prior authorization, concurrent review, and retrospective review—are performed by physicians, case managers, DMA staff, and several professional organizations under contract to DMA. Physicians have primary responsibility for managing utilization as they must determine for each beneficiary whether a service is medically necessary. For many primary care services, this medical necessity determination by a physician is sufficient. In some cases a beneficiary must have a formal "plan of care" developed by a physician and/or case manager, and signed by a physician. This is necessary for some services that require close physician supervision, such as adult care home services and personal care services. Some Medical Policy units are staffed with medical professionals who review and authorize services. DMA staff review requests for some specific prescription drugs, exemptions to the hearing aid and durable medical equipment policies, and private duty nursing.

The bulk of utilization management activities, however, are performed by external companies, as shown in Exhibit II-8 below.

Exhibit II-8. Utilization Review/Prior Approval Duties of Various DMA Contractors

EDS	Medical Review of NC	First Health	Value Options
▪ Institutional level of care for the mentally retarded ▪ Pre-admission nursing facility level of care ▪ Certain adult outpatient mental health visits ▪ Durable medical equipment, hearing aids, eyeglasses ▪ Certain hospital inpatient and outpatient services ▪ Certain dental services ▪ Prior approval for certain services	▪ Ongoing nursing home level of care ▪ Retrospective review of inpatient hospital claims ▪ Retrospective review of services provided under the CAP/DA program	▪ Inpatient psychiatric treatment ▪ Psychiatric Residential Treatment Facility services ▪ Nursing facility pre-admission screening ▪ Retrospective pharmacy utilization review	▪ Child outpatient mental health visits after the 26th visit ▪ Levels II-IV residential psychiatric treatment

EDS	Medical Review of NC	First Health	Value Options
provided for Medicaid Pregnant Women			

There is nothing inherently wrong with dividing up responsibilities among multiple utilization review contractors who specialize in specific benefit areas; many states use this approach. A concern in North Carolina is that different aspects of the same benefit may be handled by different contractors. These artificial divisions can limit DMA's ability to enforce prior approval requirements or negatively affect continuity of care.

For example, if a physician recommends that a patient be admitted to a nursing home, reviews by two separate contractors must be performed. First Health must conduct a pre-admission screening and resident review (PASARR) to meet the federal requirement for mental illness/mental retardation screening, and EDS must determine the medically necessary level of care. If First Health finds that a person does not need special psychiatric care, then it gives a PASARR authorization number to the admitting physician. This PASARR number is supposed to be relayed to EDS.

Until recently, the EDS system could not check to make sure that the PASARR number provided by the nursing home is a valid number authorized by First Health; in fact, there was no direct communication between EDS and First Health cross-referencing authorization numbers, nursing facilities, or beneficiaries. Therefore, it was possible for a nursing home to submit a false PASAAR number and receive payment for unauthorized stays. After identifying the consequences of this disconnect, DMA staff formed a working group with the two contractors involved to develop a solution. The working group has developed a new process which will require approximately $24,000 to program into the claims processing system. This change is scheduled to be completed in May 2001. This is a good example of how feedback between the Medical Policy Unit, providers, the claims processor, and the Program Integrity Unit was effectively used to identify a problem and create a solution. We credit the staff at DMA for solving this problem.

In addition to these administrative problems, the division of responsibilities between multiple contractors for services along the same continuum of care can compromise patient care. As discussed in greater detail in the behavioral health discussion in Chapter III, three different contractors are responsible for authorizing different levels of residential care for children and adolescents. Since the distinctions between the levels can be somewhat subjective, different interpretations between different contractors can create delays and barriers to access for children in need of intense psychiatric care. DMA has a process to help resolve differences of opinion between contractors but even with this process delays may occur in approving necessary care.

While there are many reasons why DMA has chosen to divide utilization management responsibilities between

Recommendation

✓ Evaluate how to better align utilization review contractor scopes of work to reduce coordination problems

multiple contractors, these unintended consequences that create barriers to care and compromise program integrity seem almost inevitable within the structure DMA has created. DMA should continue to review feedback on these situations and other problems that may have arisen before re-procuring any of these external utilization review services to determine if there might be a better way to coordinate these functions by modifying contractor scopes of work (or eliminating one or more contractors) to reduce overlapping roles.

2. *Administrative expenses are kept low*

Many DMA staff interviewed for this study expressed their pride in keeping Medicaid program administrative costs very low. The Medicaid program operates with a relatively small administrative budget—DMA administrative costs accounted for only 2.3 percent of total Medicaid spending in SFY99, which is far below the national average in Medicaid programs of about 4.0 percent. While containing administrative costs is an important goal, it is also important that a sufficient amount of resources be available to support program integrity. In many ways, up-front investments in administrative resources may result in greater cost savings for the program through stronger utilization control, cost avoidance, and more efficient recoupment of inappropriate payments.

Limiting the size of the administrative staff can help control costs and reduce waste and inefficiency. However, having a minimal number of staff can lead to overloads and bottlenecks, compromising staff members' ability to appropriately design, implement, and enforce Medicaid coverage policies. For example, throughout most of the 1980s, DMA had a roster of specialty physician consultants available to assist DMA staff in evaluating the clinical aspects of coverage decisions. The low fees paid to these doctors (less than $50 per hour) and their concerns about risk and liability have led to a substantial decrease in the availability of these clinical resources. The Medical Policy Unit of DMA employs only one physician (the Medical Director). EDS, the fiscal agent (Medicaid claims processor), which many DMA staff use as a back-up resource for interpreting medical policy, has only one full-time physician dedicated to Medicaid as well. This level of physician resources appears to be less than fully adequate, as several policy staff commented that additional clinical input into policy development and interpretation was needed, given the size and scope of the program. For example, the lack of specialist physicians to consult with leads to some of DMA's reliance on "community standards" for coverage decisions rather than clinical best practices when designing Medicaid benefits, a problem discussed earlier in this chapter.

The limited administrative resources available also compromises DMA's ability to properly manage benefits and ensure that they are delivered appropriately. The Program Integrity Unit, which reviews service delivery on a retrospective basis (after costs have been incurred), has said that "more prior approvals would be good" to prevent inappropriate expenditures in the first place, but "this would slow down the system and require more staff." Medical Policy Unit staff concurred and said that "good utilization management tools require personnel to administer them," and "some of the sections at DMA could possibly need additional staff if they were going to do more utilization

Recommendation

✓ Pursue developing new administrative resources that are necessary to administer and manage the Medicaid benefits

management." We concur and believe that additional resources, in combination with a philosophical desire to manage utilization, are needed.

While it is important that administrative spending not be wasteful, it is equally important that it be sufficient to enable the Medicaid agency to ensure that services are being provided in accordance with policy. Additional administrative spending in some areas (e.g., prior authorization for more services) may also result in decreased spending on inappropriate services. As noted earlier and discussed in detail in Chapter V, the cost of performing additional prior review in some areas will likely be more than offset by the savings in avoided service utilization.

3. *Medicaid services provided by sister agencies are not closely managed*

As described earlier in this chapter, the incentive to maximize federal Medicaid funding to other state agencies, so that the agencies can receive federal as well as state funding, has influenced a number of Medicaid policies. In many cases, these policies are structured to maximize the use of these public agency services and consequently, maximize the amount of federal revenue paid to state agencies for providing these services. For Medicaid services provided by both state and private practitioners, utilization management policies are often designed to encourage use of public providers over private providers. This consistently leads to an emphasis on federal revenue to sister agencies over a "level playing field" with privately-provided services.

For example, many disabled children require frequent treatment in special education programs to improve motor and speech skills. These services are often provided in school-based settings, as a provider can treat many children in one location, and these services are often needed specifically to help children succeed in school. Providers can be either independent private practitioners who travel to schools to provide the services, or employees of the school district who serve children at specific schools. Under current North Carolina Medicaid rules, independent practitioners who provide services in schools are subject to prior authorization requirements; therapists employed directly by the school districts are exempt from these requirements. An independent practitioner cannot provide a service without prior approval from the State. A school employee can provide the same service and the school district can submit the bill without any prior review.

Currently, this lack of review for school-provided services creates the possibility for over-utilization by public school-employed providers. Of particular concern is the fact that many school districts in North Carolina contract with third-party billing agencies to compile and submit the bills for reimbursement. These vendors generally receive up to 20 percent of the reimbursement for each claim they submit, and therefore have an incentive to submit bills for as many services as possible, leaving it to the State's fiscal agent to determine the appropriateness of each claim. This practice, common in many other states in addition to North Carolina, has come under increased scrutiny by the federal government because of the opportunities for fraud and abuse.[2]

[2] Questionable Practices Boost Federal Payments for School-Based Services, General Accounting Office, June 1999.

DMA is in the process of leveling these criteria by removing the prior authorization requirements now imposed on private providers that have not been imposed on public school employees. While this reform addresses the equity issue, linking these pediatric special education services through the child's primary care provider – either by requiring the primary care provider to approve all school-based services or at least ensuring the primary care provider is notified about these services – will ensure the child's overall health care is well-coordinated.

Other benefits have also been structured specifically to maximize the federal matching funds with less consideration to whether the public provider is the optimal source of care. For example, adults are limited to 24 physician visits per year, which includes outpatient mental health visits to providers in private practice. An adult can visit an Area Mental Health Authority (Area Program), overseen by DMH/DD/SAS, an unlimited number of times. In addition, an adult can only see a private practice psychiatrist or psychologist twice before being required to seek approval for additional visits, while prior approval is not required for visits to an Area Program provider.

Recommendation

- ✓ Consider eliminating preferential rules that favor public providers. Maximizing federal revenue to these providers may inappropriately discourage private provider participation in delivering these benefits
- ✓ Require communication between school-based providers and a child's primary care provider regarding all school-based services

These restrictions effectively induce beneficiaries to use Area Programs instead of private practitioners for outpatient mental health service and render the limit effectively meaningless. This exception is premised, in part, on ensuring access to care, a principle that on its face also would apply to care delivered by private providers. A psychiatric expert from WVMI who reviewed this policy for our study noted that neither limitation is appropriate—24 unrestricted visits may be too lax, while requiring prior approval after two visits may be too restrictive. A more appropriate number of unrestricted visits, based on clinical standards instead of incentives to steer patients to certain providers, might be 12 visits to either type of provider.

While obtaining federal revenue for publicly-supported safety net providers is a laudable goal, it must not come at the expense of clinical appropriateness or program integrity. Policies that induce beneficiaries to rely on public providers may hamper DMA's other efforts to "mainstream" Medicaid care by enrolling high numbers of private providers. The range of potential impacts of these policies (e.g., access, program integrity, clinical quality) should be considered in addition to the revenue benefits when evaluating policies that support public-sector providers.

III. REVIEW OF KEY BENEFITS

As noted in the Introduction, DMA's emphasis on access has led to certain consistent decisions that are reflected in the amount, scope, and duration of Medicaid services. This section discusses the effect of DMA's approach on the major budget items in the Medicaid benefit package.

A. Inpatient Hospital Services

Inpatient hospital services are a mandatory component of a state Medicaid program under federal law. DMA has done an excellent job managing the inpatient hospital component of the Medicaid program. Service definitions and medical necessity criteria are clearly outlined and in accordance with current medical practices (see Appendix A for more detail). DMA uses widely accepted Intensity Severity Discharge acute care criteria (known as ISD-A) during post payment reviews, and has generally met with success in recouping funds in cases where utilization was inappropriate. By eliminating pre-admission review at the suggestion of its utilization review contractor, DMA has demonstrated a willingness to tailor policies to the current environment. In short, the inpatient hospital section could serve as a case study on how to develop relevant medical policies and appropriately manage service utilization. It honors Exhibit I-4 in the Introduction.

Recent spending trends highlight DMA's success in managing the inpatient hospital benefit. Though inpatient hospital services remain the second largest expenditure item in the Medicaid budget, the cost per unduplicated user actually declined from $4,107 to $3,906 between SFY98 and SFY00. Moreover, its share of the Medicaid service budget has decreased slightly, from 16 percent in FY98 to 15 percent in FY00. These trends can be attributed to strong utilization management techniques that eliminate unwarranted utilization.

State Fiscal Year	Total Expenditures	Share of Service Budget	Unduplicated Users	Cost Per User
1998	$705,744,660	16%	171,848	$4,107
1999	$683,536,611	16%	173,906	$3,930
2000	$736,135,229	15%	188,141	$3,906

Source: DMA Financial Statistics

Medical Review of North Carolina (MRNC), DMA's utilization review contractor, reviews 425 cases each month using ISD-A criteria. According to WVMI, these discharge criteria are the industry standard for acute care and are the real strength of DMA's utilization management approach. MRNC reviews neonatal cases, "upward" cases (where hospitals may be upcoding the severity of cases to maximize reimbursement), DRG 468 and short stay hospitalizations, checking for the medical necessity of hospitalizations and identifying cases where subacute care may be safe and cost-effective alternatives to inpatient care. MRNC nurses perform the initial reviews, but physicians perform follow-up on any cases that have been flagged, where the nurse disagrees with the code or has questions. In instances where utilization was inappropriate, MRNC calculates the amount of overpayment and notifies the appropriate hospitals. DMA's Program Integrity staff follow-up with the facilities and perform the actual recoupments.

While most inpatient utilization management programs require some form of pre-admission or concurrent review, DMA has decided to only perform retrospective reviews. At one time, MRNC did perform pre-admission reviews for DMA, but this requirement was dropped after the contractor notified DMA that few patients were being denied admission. As such, the administrative cost of the process and the accompanying burden was not justified by service costs avoided. This is an excellent example of how DMA's Medical Policy Unit utilized the feedback from an outside agent to inform its decision-making and make timely adjustments to policies. Moreover, DMA showed that it was willing to try progressions of various utilization management techniques until it determined which method was the most effective.

DMA's medical necessity criteria in hospital services are appropriate. For example, DMA will not cover out-of-state care except in cases of emergency or in situations where beneficiaries can document that the care is not available within North Carolina and obtains prior approval from the fiscal agent, EDS. This policy is similar to those of most HMOs, and WVMI believes that it is adequate and relevant. The service definitions for inpatient services are clear and well defined. Indeed, the Medicaid Hospital Manual specifies which inpatient procedures require prior approval from the fiscal agent as well as the surgical procedures that are not covered under Medicaid. The latter are identified by ICD-9 procedure code, and the fiscal agent system will not reimburse physicians or facilities that try to submit claims for these codes.

B. Nursing Facility Services

As a benefit mandated by federal law, skilled and intermediate nursing facility care is a prominent component of North Carolina's Medicaid program. Nationally, Medicaid is often the largest payer of nursing facility care, and indeed, Medicaid beneficiaries occupied nearly 85 percent of available licensed beds in skilled and intermediate nursing care facilities statewide in 1999. In SFY00, North Carolina spent approximately $810 million on nursing facility services, making it the largest service expenditure in the Medicaid budget (see Appendix A for more detail).

1. Prior authorization overview

The Institutional Services section within the MPU has established a strict prior authorization process to monitor admissions of Medicaid beneficiaries to nursing facilities. The prior authorization process is comprised of the following components:

- Prior to being admitted, the hospital discharge planner, receiving nursing facility, or county social services staff contacts First Health to conduct a pre-admission screening and annual resident review (PASARR)[1] for the patient. The PASARR ensures that an independent mental health professional assesses individuals to determine the presence of mental illness or

[1] The Omnibus Budget Reconciliation Act of 1997 required that states conduct pre-admission screening and annual resident reviews (PASARR) of all nursing home applicants and residents to prevent inappropriate placement of people with mental disabilities in a Medicaid-certified nursing facility. States are also required to review on an annual basis all residents who are mentally ill or mentally retarded to determine whether their continued placement in an institution is appropriate.

mental retardation. If at least one of these conditions is present, the patient may not be suitable for nursing facility care.

- The patient's attending physician signs and dates the long-term care services form (known as the FL-2), documenting the medical necessity for the nursing facility stay and recommending the appropriate level of care (e.g., skilled, intermediate, ventilator). The PASARR number supplied by First Health must be included on the FL-2 for the stay to be authorized by EDS. The completed and signed FL-2 is sent to the county social services office.

- The county forwards the FL-2 to the EDS Long Term Care Prior Approval Unit. EDS nurse reviewers determine the appropriateness of the recommended level of care based on criteria developed by the Institutional Services section. If approved, a system-generated Service Review Number, or SRN, is assigned and EDS forwards copies of the FL-2 to the patient's county social services office. The county then forwards a copy to the receiving nursing facility.

- If the requested level of care is not supported by the documentation, the FL-2 will be sent back to the county social services office with a letter indicating the need for additional information. The county and/or facility may submit the additional information for reevaluation.

In a new policy that is scheduled to go into effect on July 1, 2001, the originator of the FL-2 (i.e., hospital, physician's office, or nursing facility) can transmit the form directly to EDS for prior authorization. This policy should streamline the current prior authorization process. DMA is to be commended for this solution.

Findings

The prior approval process appears to be expedient and well coordinated. The two contractors involved have clearly defined roles with no duplicative or overlapping functions. First Health administers the PASARR and determines whether a patient with mental illness/mental retardation is suitable for nursing facility care. EDS' role is to determine whether the patient meets criteria for nursing facility or adult care home level of care. Neither contractor, though, is involved in evaluating whether the patient is a suitable candidate for the Community Alternatives Program (CAP) as an alternative setting of care. In contrast, utilization contractors in several other states play joint roles to avoid unnecessary institutional options, as discussed in more detail in Chapter III.

2. Utilization review overview

DMA has established several protocols to monitor the appropriateness of level of care changes (e.g., when a patient is transferred from intermediate to skilled nursing care because his or her condition worsens). These include the following:

- Per state regulations,[2] nursing facilities are required to convene a utilization review committee (URC) to evaluate the care and medical needs of Medicaid beneficiaries. All new admissions are reviewed at the first scheduled URC meeting subsequent to the admission.

- Skilled nursing recipients are reviewed by the URC at 30, 60, and 90 days after the admission, and every 90 days thereafter. Intermediate nursing recipients are reviewed on a similar schedule, except they are reviewed every 180 days after the admission.

- Using DMA's level of care criteria, the URC determines whether requests for changes in the level of care are medically appropriate. All URC reports must be submitted to DMA within 48 hours after the URC meeting. Level of care changes resulting from URC recommendations are processed at DMA.

- DMA notifies by mail the resident, attending physician, facility and county social services office of the decision regarding the level of care change, and of the resident's right to appeal if he or she disagrees with the decision.

These measures are quite stringent and require DMA and the nursing facilities themselves to invest significant amounts of resources to be in compliance with the review process. For example, approximately 8,000 FL-2s are completed each month by nursing facilities; DMA staff manually sort the forms, and DMA nurses review cases where the level of care has changed. The sheer administrative burden of processing the forms alone is quite heavy for the Institutional Services staff, and there are only four nurses in the section to review cases.

To buttress the reviews of its own nurses, DMA contracts with MRNC to monitor the appropriateness of level of care changes in a sample of cases. Each month, MRNC reviews 1,000 cases selected by DMA to determine whether the level of care change is justified based on DMA's level of care criteria and the supporting medical evidence. MRNC will ask the nursing facility to submit the most recent month of medical records if there are questions concerning the level of care change. If the additional documents still do not support the URC's level of care recommendation, a change will be effected and MRNC will notify by mail the resident, attending physician, facility and county social services office of the denial and the resident's right to appeal.

Findings

Level of Care Criteria

According to statistics compiled by MRNC, the level of care change was denied in approximately 28 percent of cases that it reviewed. Moreover, in nearly two-thirds of the cases where MRNC requested additional medical documentation, MRNC deemed the level of care to be inappropriate. The rate of denials suggests that perhaps there are ambiguities with DMA's nursing facility level of care criteria, leaving room for differences in medical opinion between DMA, MRNC, and the nursing home utilization review committees.

[2] Per 10 NCAC .26B .0108, 26B .0116.

Indeed, WVMI found that while DMA's level of care criteria were generally sufficient and consistent with the long-term care standards established by Medicare and private insurers, there were specific areas that needed further clarification or quantification. For example, Medicaid policy states that one of the conditions for skilled nursing care is clinically significant weight loss "in relation to the resident's total body mass". DMA does not quantify weight loss thresholds, though, so it is unclear as to when a resident's weight loss is clinically significant. WVMI suggests that DMA establish thresholds based on a percentage of a defined baseline value. WVMI's other findings and suggestions in this area include:

- Self-care instruction, as well as instruction to the care-giver, should be included in the skilled nursing needs assessment for gastrostomy, tracheostomy, uncontrolled diabetes, treatments (e.g., oxygen, hot packs, hot soaks), and special therapeutic diets.

- DMA should evaluate whether an acute care qualifying stay prior to placement at the skilled level be included as a component of its skilled nursing criteria.

- Based on its knowledge and experience of West Virginia's intermediate nursing care criteria, WVMI believes that DMA needs to quantify the extent to which a patient needs assistnace with activities of daily living (ADL). One ADL deficit – such as an individual who cannot bathe himself/herself without assistance—should not be adequate grounds to receive intermediate nursing care. DMA should establish minimum thresholds, such as deficits in three out of five ADLs, to establish a more rigorous standard.

Appeals and Contested Decisions

Even when told to bill at the lower rate after the review, a provider can continue billing at the higher reimbursement rate if the recipient contests the decision and files an appeal with DMA. Because of a shortage of hearing officers, DMA is slow to hold appeals hearings; currently, appeals are being scheduled for six weeks after the request is made (despite program requirements to process appeals within shorter timeframes). Given the high reimbursement rates for intensive nursing home services (over $120 per day for skilled nursing care), these delays can result in thousands of wasted dollars per case, especially if MRNC's original determination—that the level of care was too high—is upheld. Hence, the facility has nothing to lose, and everything to gain, in contesting all downward level of care changes since it will retain all (higher) payments during the appeals period.

This situation is an example of how pressure to keep administrative costs low may inadvertently have the opposite effect. The addition of more hearings officers will reduce the backlog and help DMA process appeals more quickly. This means that savings from reducing the level of care can be achieved more quickly. DMA estimates that two additional hearings officers are needed at an approximate annual cost of $90,000. By speeding up the process, these officers may be able to help the state save up to $500,000 annually by paying for a lower level of care more quickly. We concur with these estimates, and urge the state to move forward.

Other Findings

There appears to be some duplication of efforts between MRNC and nurses in the Institutional Services section. DMA nurses perform their own review of cases, overlapping the utilization review activities of MRNC. Furthermore, both DMA and MRNC send denial notification letters to recipients. The Institutional Services section should reexamine this review process and how it impacts staff workload.

A final concern is the compliance of nursing facilities in sending medical records to MRNC when requested. In 10,727 cases where MRNC requested additional medical documentation, nursing facilities complied with the request only 85 percent of the time (see table above). Admittedly, the records were not sent in some of these instances due to resident death, discharge, transfer, or termination of Medicaid coverage, but nursing facilities have the option of ignoring the request. Indeed, DMA does not penalize facilities for failing to comply with MRNC's request.

Recommendations

- ✓ Revise level of care criteria where necessary to eliminate ambiguities;
- ✓ Educate providers and contractors about the new criteria;
- ✓ Consider hiring one or two additional hearing officers to expedite appeals;
- ✓ Clarify ambiguous policies, such as the "weight loss" threshold;
- ✓ Eliminate duplicative administrative tasks between MRNC and DMA; and
- ✓ Sanction providers that fail to comply with documentation requests.

3. DMA activities

The Institutional Services section recognizes the shortcomings of the current utilization review method and is in the process of examining alternative methods to contain spending and improve quality assurance protocols. For example, it has performed some preliminary analyses to determine the feasibility of using a case-mix adjusted prospective payment system, similar to Medicare's Resource Utilization Group (RUG) and Minimum Data Set (MDS) systems, to determine the level of care. This method allows for greater sensitivity in assigning patients to the appropriate level of care, thereby reducing the error rate in level of care determinations. In addition, utilization review will no longer be based on the FL-2; rather, DMA nurses would review cases using the MDS criteria, which provide a more comprehensive assessment of resident's functional capabilities and health problems and allow for a larger sample size than the current 1,000 cases per month.

C. Pharmacy

Though the pharmacy benefit is technically an optional Medicaid covered service under federal guidelines, North Carolina, like all states, has made prescription drug coverage one of the cornerstones of its Medicaid program. All Medicaid beneficiaries in North Carolina, regardless of eligibility category or conditions of coverage, are eligible for prescription drug coverage.

While North Carolina's prescription drug spending has historically been close to national averages, many other insurers and Medicaid agencies have taken actions in the past several years to contain the rate of growth in pharmacy expenditures.

From SFY98 to SFY00, North Carolina Medicaid's prescription drug costs grew from $455 million to $754 million, an average annual increase of 29 percent per year.[3] Part of this increase is related to the eligibility expansion that added 35,000 aged, blind and disabled beneficiaries with average prescription drug costs of nearly 10 times that of the welfare related aid categories. In SFY00, North Carolina's per beneficiary per month costs of prescription drugs for the elderly and disabled were $170 and $159 respectively, as compared with costs for families and children of about $17 per month. If the numbers of beneficiaries and their distribution across eligibility categories were held constant from SFY99 to SFY00, the net increase in prescription drug costs over this time period would be 25 percent (as compared with a gross increase of 35 percent).

a) Prior Authorization

DMA's position on prior authorization of pharmaceuticals is in keeping with the agency's long-standing history of minimizing administrative costs and maintaining broad access to and coverage of benefits. In the opinion of DMA's Pharmacy Director, prior authorization programs are not cost-effective because the amount spent on the administrative process would exceed any cost savings on the actual prescriptions averted, which has led to a pharmacy program that lacks a rigorous utilization management protocol.

DMA's lack of prior authorization for costly brand drugs is surprising when considered against the backdrop of industry-wide pharmacy management practices. Approximately 90 percent of managed care organizations have aggressive prior authorization programs for drugs.[4] We surveyed five states—Arkansas, Florida, Georgia, Oklahoma, and Oregon—to obtain more information about their prior authorization programs, which are further described in Chapter IV. In addition, WVMI utilized a pharmacy expert to review North Carolina's practices; his report can be found in Appendix H.

Federal regulations limit the ability of state Medicaid programs to institute the types of cost containment strategies (e.g., three-tiered co-payment systems with co-pays that range from $5 to $45) that other payers have used in recent years to contain cost growth in prescription drugs. Given these restrictions, state Medicaid programs are increasingly using prior authorization in their pharmacy programs. There is a wealth of medical literature demonstrating the importance of prior authorization in state Medicaid programs in controlling drug costs and eliminating unwarranted utilization of expensive brand drugs. Several key findings include:

- An evaluation of the prior authorization program in Iowa Medicaid found that total net savings for antiarthritics, benzodiazepines, antiulcer drugs, and antihistamines was estimated to be between $2.5 million and $3.8 million, representing two to three percent of payments.

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[3] Division of Medical Assistance Financial Reports, FY98; FY00.
[4] Ibid.

- A 1997 study[5] of the prior authorization program in West Virginia Medicaid found that the total savings for three types of drug classes (peptic acid disease, gastrointestinal motility, and brand name non-steroidal anti-inflammatories, or NSAIDs) was estimated to be $9.3 million. The total cost of the prior authorization program (which included 12 other drug classes) was approximately $580,000, or a net return on investment of $16 for every $1 spent on administration.
- Upon implementation of its prior authorization program for brand name NSAIDs, Georgia Medicaid experienced an immediate increase in the use of generic equivalents. The program resulted in projected annual savings of $7 million, with no increase in the use or cost of physician or hospital services during the seven months after the program began[6]. A similar program in Tennessee Medicaid resulted in savings of approximately $12.8 million over a two-year period, with no concurrent increase in other medical expenditures[7].
- In its 2000 annual report,[8] Florida Medicaid estimated that prior authorization of four drugs (serostim, cytogam, epogen, procrit/neupogen) would achieve annualized cost savings of approximately $89 million.

In light of this evidence, we strongly recommend that DMA implement a prior authorization program to manage utilization of at least a handful of costly brand name drugs. Indeed, a review of the 100 most prescribed drugs (by total expenditures) in North Carolina reveals that there are several relatively new, high cost drugs (see table below) that have been the source of increased expenditures in many Medicaid and private sector drug benefit programs.[9] Medicaid programs in 42 other states, such as Iowa, have instituted prior authorization programs for similar drugs in order to maintain access to necessary pharmacy services within budgetary limits. We believe that if DMA adopts an approach similar to Iowa's, it could realize up to $55 million in pharmacy expenditure program savings ($17.9 million of which are state funds).[10] As described below, the net savings would be less, due to the administrative costs of implementing the utilization control program.

We recognize that initial investment in infrastructure (e.g., programming the EDS claims processing system to allow for prior authorization of brand drugs) and staff will be necessary to realize cost savings of the magnitudes alluded to above. These start up costs are substantial, but in the long term, states have demonstrated that their return on investment is substantial. Georgia,

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5 Moores, K., Focused Review of NC Medicaid Pharmacy Program, p. 2.

6 Kotzan JA, McMillian JA, Jankel CA, Foster A., Initial impact of a Medicaid prior authorization programs for NSAID prescriptions J Res Pharmaceut Econ 1993;5:25-41, as cited in Moores, p. 3.

7 Smalley WE, Griffin M, Fought, Sullivan L, Ray WA. Effect of a prior authorization requirement on the use of nonsteroidal anti-inflammatory drugs by Medicaid patients. N Engl J Med 1995;322:1612-1617, as cited in Moores, p. 3.

8 Florida Agency for Health Care Administration, Annual Report of Medicaid Prescribed Drug Spending Control Program, January 2001, p. 20.

9 Moores, p. 1.

10 Moores, p. 2.

Exhibit III-1. Projected Cost Savings from Prior Authorization of Select Drugs

Drug Name	Total Expense 2000[1]	Projected Potential Expense Reduction[2]
Prilosec	$ 36,282,850	$ 25,500,000
Prevacid	$ 23,481,230	$ 13,800,000
Aciphex	$2,562,802	$1,500,000
Ranitidine 150mg	$6,371,835	($ 2,000,000)
Pepcid	$5,366,912	($ 1,700,000)
Axid	$2,308,959	($ 700,000)
Celebrex	$ 15,036,600	$ 11,200,000
Vioxx	$ 10,010,600	$ 7,750,000
"other branded NSAIDs"		neutral
Total		$55,350,000

Source: Moores, K.

[1] Based on data from January 2000 to December 2000 on top 100 drugs (by expenditures) in a report furnished by DMA. Excludes additional dosage forms or strengths of these drugs that did not appear on the top 100 list.

[2] These projections are estimates only. The actual reduction will depend on the effectiveness of the program implementation process, and the demographic comparison of the Medicaid population in the respective states, which was not considered in the calculations. These projections are based on estimates considering the expenses for these drugs as percentage of total expenses for medications in North Carolina to the comparable data in Iowa, where prior authorization is required. (Attachment I) Expenses for H2RA may increase as some of the PPI use is shifted to H2RA. Other NSAIDs will be used to replace the COX-2 inhibitors, with an emphasis on use of generic NSAIDs the effect is expected to be neutral, however this is based on limited information about current NSAID use.

for example, saves $16 for every $1 it spends on the administration of its pharmacy prior authorization program. Applying these figures to North Carolina, the state would spend approximately $3 million in administrative expenses to operate a prior authorization program, which would still result in net savings of over $50 million a year (or net savings of $16.3 in state funds).

Recommendation

✓ Implement a meaningful prior authorization program for at least the eight drugs listed in Exhibit III-1

While DMA does have a policy that pharmacists dispense generic drugs unless the prescriber specifically orders the brand drug, there is no further requirement for external review, even for certain high cost drugs. Overall, generic drugs are dispensed in North Carolina Medicaid about 50 percent of the time. In our review of a group of often-prescribed brand drugs and their generic equivalents, the brand drug was dispensed just over 53 percent of the time, as shown below. If DMA could increase the rate of generic substitution to 75 percent for just the seven drugs shown in this chart, prescription drug costs would fall by $3 million per year.

Exhibit III-2. Proportion of Prescriptions by Drug Type that Generic Drug Was Dispensed

Example Brand Names	Generic as % of Total Prescriptions 2000
Synthroid	7%
Norco/Lorcet	97%
Ventolin/Preventil	99%
Amoxil/Trimox	41%
Lanoxin/Digitek	11%
Coumadin	17%
Vasotec	23%
Clozaril	31%
Methlyn/Ritalin	80%
Tegetrol/Carbatrol	42%
Subtotal	53%

Source: DMA data, analyzed by The Lewin Group.

b) Scope of Benefits

The scope of the pharmacy benefit includes a provision that limits the per month utilization of prescription drugs while allowing for extended days' supply of drugs. DMA allows beneficiaries to receive up to a 100-day supply for a given drug, about three times higher than the states we surveyed (see Exhibit III-3). At the same time, DMA does limit beneficiaries to six prescriptions per month, with a provision to make exceptions in certain instances. As a result, the six prescription monthly limit may be in effect, but beneficiaries could be staggering 100-day supplies of 18 medications over three months. The Pharmacy Manual notes that this is an acceptable practice, stating "Some prescribers may elect to write some prescriptions for more than a month's supply for those recipients who exceed this six prescription limit due to the number of recurring medications they must take for chronic conditions."

Exhibit III-3. Monthly Prescription Limit and Maximum Days Supply by State

State	Monthly Prescription Limit*	Maximum Days Supply
North Carolina	6	100
Arkansas	3	31
Florida	4 (brand limit)	34
Georgia	5 (adults); 6 (kids)	31
Oklahoma	3	34
Oregon	Unlimited	34

Source: Surveys conducted by The Lewin Group

* Note: With the exception of Georgia, these prescription limits apply to adults only.

(1) 100-day Supply Policy

One of the pitfalls of having a high supply limit (such as 100 days) is that the full supply of the medication may not be consumed before the recipient requests another prescription of either the same or a similar drug. For example, if a 100-day supply of an expensive psychotropic is dispensed, but the beneficiary switches to a new drug after 25 days due to side affects or ineffectiveness, 75 days of the expensive drug are wasted. As discussed in more detail in Chapter IV, this is one of the reasons that private insurers usually do not authorize long term supplies of medications for people with chronic conditions until after an initial test period is completed. Another difficulty with a high supply limit in the case of Medicaid programs is that beneficiaries may be receiving prescription drugs that cover them beyond the duration of their Medicaid eligibility (an therefore beyond the states' financial responsibility for their care). For these reasons, most states have a shorter maximum supply.

DMA's Program Integrity Unit has the capability through its Spotlight surveillance system to uncover cases where pharmacists refilled the same, or a similar drug, before 40 percent of the supply is consumed, but it requires significant resources to recoup these funds during post payment reviews. The Program Integrity investigator must visit the pharmacy, confirm the amount of the drug that was dispensed, and perform recoupments if necessary. By reducing the supply limit, the potential for this type of overutilization will likely shrink.

DMA has held preliminary discussions to reduce the 100-day supply maximum to a 30-day limit, but it is unclear whether and when this policy change will take effect. We encourage DMA to proceed with a change to a maximum 34-day supply, especially for first-time prescriptions to a given patient, since only about 20 percent of all prescriptions would be affected (see Exhibit III-4).

Exhibit III-4. Distribution by Days Supply of NC Medicaid Prescriptions, 2000

Days Supply	Number of Prescriptions	Percentage of Prescriptions
0-30	13,032,909	81.4%
31-60	2,529,799	15.8%
61-100	438,414	2.7%
Total	16,001,122	100%

Source: DMA

(2) Limit of Six Prescriptions Per Month

The six prescription per month benefit limit was analyzed in some detail in this study using data provided by DMA and EDS. In reviewing the approach to enforcing the prescription limit policy and granting exceptions, we found that exceptions to the six-prescription limit are easily granted to those who request them and the percentage of beneficiaries who receive exemptions is growing. At the same time, we also found evidence that the limit is very real for many beneficiaries and may have some unintended consequences, especially for the elderly and

disabled populations. The key findings from our operational and data analyses are summarized below.

From an administrative perspective, the policies and procedures around the six prescription limit seem to allow adequate avenues for exemptions. Children and CAP recipients are automatically exempt from the monthly limit, as are individuals with life threatening illnesses (e.g., acute sickle cell disease, hemophilia, unstable diabetes, end stage lung, or end stage renal disease). For the latter, the beneficiary must give to the pharmacist an override form completed by the prescriber that notes the life-threatening illness or diagnosis. There is no requirement, however, to document the medical necessity of the override by attaching a copy of the medical record or by listing the beneficiary's diagnosis code. Indeed, one of the options on the form is labeled as "any life threatening illness or terminal stage of any illness," with no further explanation or documentation required. The pharmacist is permitted, at his/her discretion, to complete this entry. Finally, there is no systematic retrospective review of the medical necessity of the override. Program Integrity does audit problem pharmacies on an annual basis (with most pharmacies routinely audited every three years), but it can only check for the presence of the override forms, not the medical necessity of the exemption.

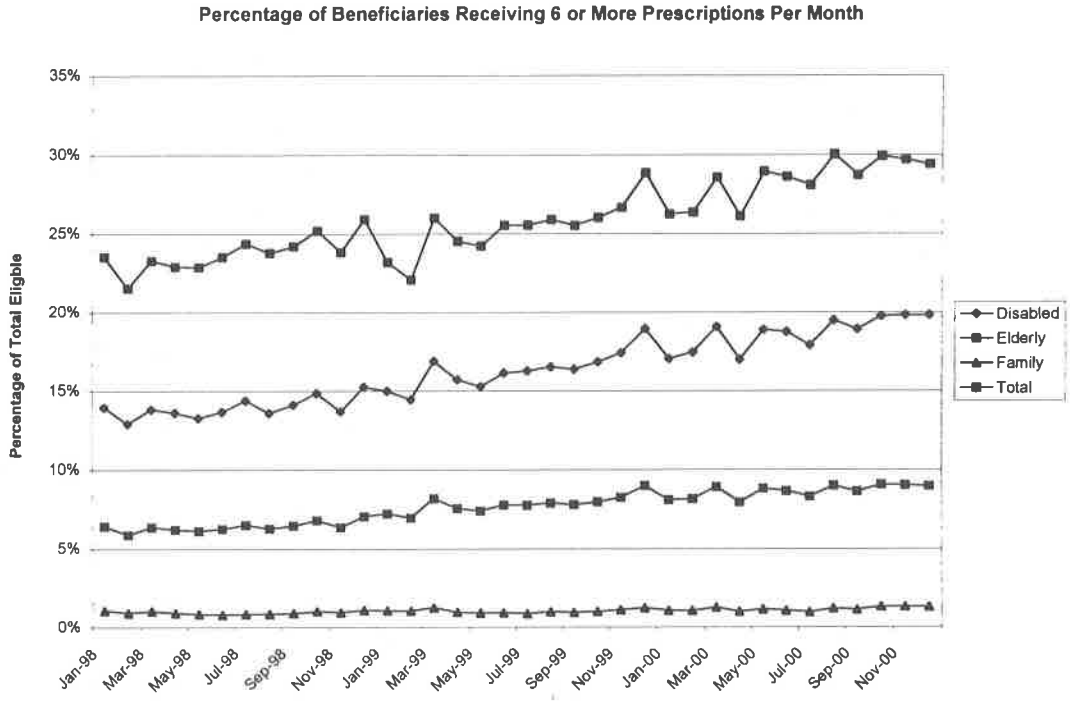
Our review of pharmacy claims shows that the proportion of Medicaid beneficiaries who receive more than six prescription per month has steadily increased[11] (see Exhibit III-5). The exemption rates are highest among the elderly, rising from seven percent in 1998 to 15 percent in 2000. Exemption rates are also high among the disabled, increasing from four percent to eight percent over the same two-year period.

While exemptions may be granted without a high degree of scrutiny, the data suggest that the limit does reduce pharmacy utilization, the consequences of which are unknown.

First, the benefit limit is affecting a sizable and rapidly growing number of Medicaid beneficiaries. Clinical practices rely very heavily on multi-prescription therapies for elderly and disabled beneficiaries. By the end of 2000, 30 percent of elderly Medicaid beneficiaries, and 20 percent of disabled Medicaid beneficiaries received at least prescriptions in any given month. Thus the benefit limit of six per month is not influencing a small number of persons on the "tail" of the distribution – it is coming into play for a very large and growing number of beneficiaries.

[11] Because we were unable to exclude children and CAP recipients from our claims sample, our findings are likely to be somewhat overstated.

Exhibit III-5. Percentage of Beneficiaries Receiving Six or More Prescriptions Per Month



Source: Lewin analysis of DMA claims data.

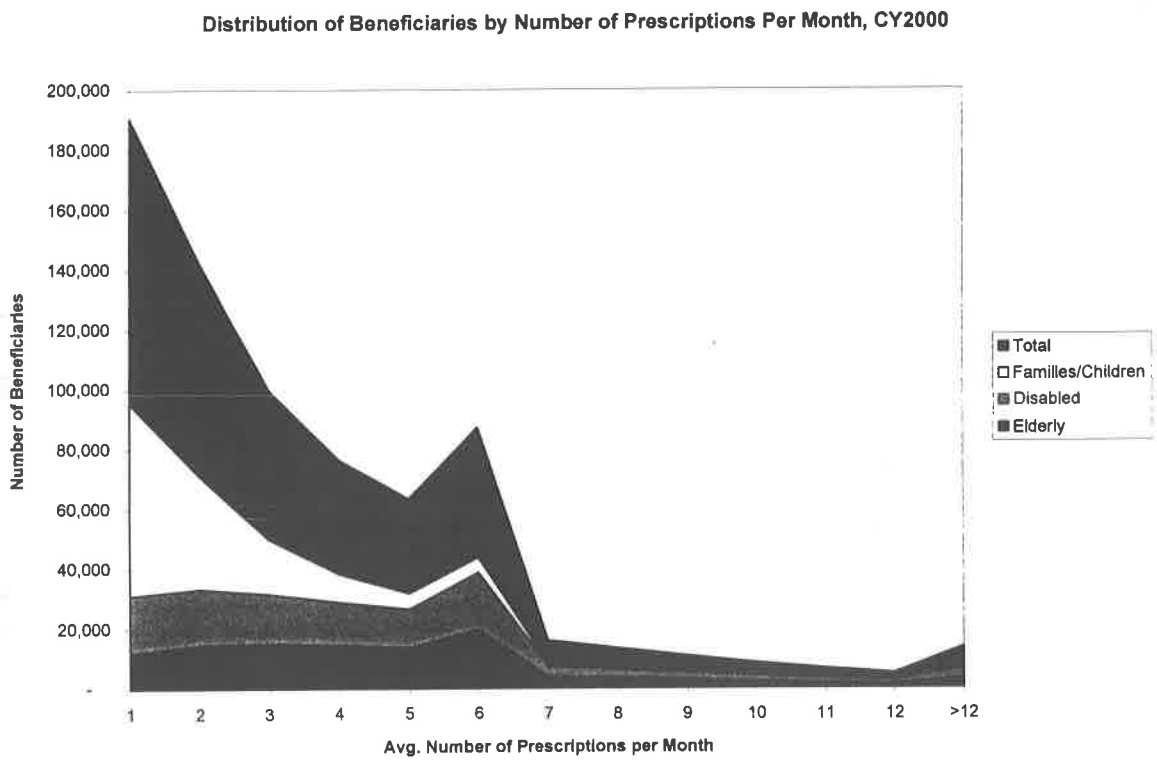
Second, the benefit limit of six is clearly having an impact on utilization. The distribution of persons by number of prescriptions received in all 36 months of the 1998-2000 period followed the same pattern.

- Most persons (59 percent in December 2000, for example) used no prescriptions in a given month.
- The number of beneficiaries using 1-5 prescriptions decreases steadily across time (e.g., in December 2000, 98,000 recipients received one prescription, with the figure steadily decreasing such that 33,000 persons received five prescriptions).
- The number of persons who received exactly six prescriptions represents an upward spike – it is always higher than the number receiving five prescriptions and deviates from the overall declining pattern. This is clearly shown in Exhibit III-6.
- The number of persons receiving seven prescriptions drops off dramatically from the number of persons receiving six prescriptions. Typically, only about one-fifth as many individuals receive seven prescriptions as receive six.
- Above seven prescriptions per month, the number of persons continues to decline steadily as the number of prescriptions increases.

The effect of the limit is even more visible when the utilization data are reviewed by subpopulation (again, see Exhibit III-6). The data show that the number of disabled beneficiaries

with six prescriptions per month is actually higher than the number of persons with four or five prescriptions per month. For both the elderly and disabled subgroups, by late 2000 there were more beneficiaries receiving exactly six prescriptions per month than any other number of prescriptions (other than zero). In other words, the limit does have an impact on the number of prescriptions purchased by DMA for these eligibility groups in a given month.

Exhibit III-6. Distribution of Beneficiaries by Number of Prescriptions Per Month, CY2000



Third, a large number of persons are receiving exemptions and thus receiving seven or more prescriptions in a given month. In December 2000, for example, 41,220 persons received seven or more prescriptions.

The use of prescription limits of this type is rare in Medicaid programs; in fact, only 14 states of use a monthly limit on the number of prescriptions.[12] Research has shown that prescription limits of this sort in Medicaid programs result in an immediate reduction in utilization of prescription drugs, but not in overall Medicaid spending. Rather, these policies may have a negative impact on clinical outcomes.[13]

This prescription limit stands in marked contrast to the prevailing pattern in North Carolina Medicaid of encouraging access to care. It represents the main benefit in North Carolina's

[12] Blumenthal, David. Institute of Medicine. Description and Analysis of the VA National Formulary. 2000. National Academy Press. Washington, DC.

[13] FDA Center for Drug Evaluation and Research Arthritis Advisory Committee meeting Feb 7, 2001 and Feb 8, 2001 http://www.fda.gov/ohrms/dockets/ac/cder01.htm#Arthiritis accessed April 7, 2001.

Medicaid package where an artificial cost containment policy may inappropriately deny needed access to care. Taking all the above into consideration, we are concerned that the six-drug limit is arbitrary and probably decreases appropriate access to needed medications without yielding overall program cost savings (as the drugs being blocked may be the most cost-effective way to address a given patient's condition). Another concern is that the clinical value of the drugs being blocked is extremely difficult to judge. We cannot address the degree to which the limit may have a negative clinical impact.

We recommend that DMA consider eliminating this limit altogether. As discussed elsewhere in this report, we believe there are other approaches to pharmacy cost containment (e.g., various prior authorization programs) that hold much greater fiscal savings potential, as well as less risk of jeopardizing access and health outcomes for program beneficiaries.

Recommendation

✓ Replace the six prescription per month limit with a more rigorous prior authorization program to ensure that cost decisions are made based on evidence-based clinical guidelines

D. Physician Services

In the course of this study we evaluated Medicaid claims data to assess two potential trends in Medicaid billing by physicians. First, we evaluated whether Medicaid has experienced "upcoding," which occurs when physicians use a billing code that pays slightly higher than another possible billing code. Upcoding is marked by a steady upward trend in this billing pattern. Second, we evaluated whether access to physician services, as measured by units of office visits per beneficiary, changed over the past few years, especially as a result of the fee increase on January 1, 2000 to 100 percent of the Medicare fee schedule.

1. Upcoding

For physician evaluation and management services (e.g., office visits, inpatient visits, consultations) most fee-for-service programs pay different amounts based on the duration of the visit. For example, there are five separate procedure codes for office visits for an established patient (CPT codes 99211-99215) that depict a typical level of physician effort ranging from a five-minute physician-patient encounter at the low end (CPT code 99211) to 40 minutes at the high end (CPT code 99215).

During the study, some staff members at DMA raised the concern that physicians might have become more inclined to bill for evaluation/management services towards the high-end of the payment scale, by, for example, billing an increasingly high proportion of CPT codes 99214 and 99215 for established patient office visits. This would mean that the physicians would be claiming that office visits proportionately are taking longer, and are getting more fees as a result. We analyzed the claims data to assess this concern. We conclude that there is not a substantial problem here.

We analyzed this issue through the following steps:

Step 1: Identify a set of 43 CPT (billing) codes where upcoding might occur.

Step 2: Obtain North Carolina Medicaid claims counts from DMA for these codes.

Step 3: Calculating average Relative Value Unit (RVU) statistics for various cohorts of evaluation and management services, physician specialty, and Medicaid coverage category, assessing the progression for the years 1995-2000.

Step 4: Calculate Average Medicare RVUs to establish benchmarks against which the average Medicaid RVUs could be contrasted.

From this analysis we found that Medicaid billing is modestly trending upward into higher complexity (and higher paying) codes. The rate of increase over the five year period is perhaps a total of three percent. At the same time, however, we found that North Carolina's physicians historically have been conservative in their coding practices, so that even after this modest increase they are using billing codes of less complexity (and payment) than their counterparts around the country.

This latter finding is based on evidence from Medicare. North Carolina physicians' average Medicare RVUs per visit are below the national Medicare average, and Medicare's claims volume provides a larger statistical reference point than does Medicaid (Exhibit III-7). If North Carolina's physicians are collectively not Medicare "upcoders," it is not likely that they are collectively upcoding their Medicaid claims.

Exhibit III-7. 1998 Average RVUs and Procedure Volume – North Carolina Medicaid and Medicare, USA Medicare

Type of Service	Weighted Average RVU, CY98			Procedure Volume, CY98		
	NC Medicaid	NC Medicare	USA Medicare	NC Medicaid	NC Medicare	USA Medicare
Initial Office Visits	2.46	2.42	2.62	134,459	353,797	11,455,624
Follow-Up Office Visits	1.32	1.32	1.40	1,698,550	5,581,911	167,751,955
Observation Services	2.69	3.00	2.87	20,648	30,054	861,945
Inpatient Visits	1.70	1.63	1.59	392,116	2,204,198	79,588,613
Office Consults	3.85	4.02	4.11	76,147	266,986	9,409,365
Inpatient Consults	2.62	2.62	2.88	52,681	356,441	13,513,642
Confirmatory Consults	2.61	2.58	2.76	916	4,444	174,099
ER Visits	1.69	2.27	2.27	371,881	487,631	13,952,614
Total Volume				2,747,398	9,285,462	296,707,857

Figures include all physician types, program eligibles

The bottom line is this: Medicaid coding practices are trending upward (at a slow pace), but they are not yet to reach "average" coding practices compared to physicians in other states. The state should keep a careful eye on this trend.

2. *Physician Units of Service*

Some DMA interviewees asserted to us that physician utilization has recently increased sharply in North Carolina's Medicaid program. Using the data collected for the upcoding analysis, we tabulated the number of visits occurring across the 43 targeted evaluation and management (E&M) CPT codes.

The figures in Exhibit III-8 are not indicative of an increase in physician service volume, even following the fee increase on January 1, 2000. While these visits depict usage for only 43 CPT codes, these procedures typically account for over one-third of physicians' revenue and visit usage trends tend to be a sound indicator of overall physician service volume trends.

Exhibit III-8. Physician Units of Service: 1995-2000

Procedure Volume					
Type of Service	**Setting**	**1995**	**1998**	**1999**	**2000**
Initial Office Visits	All	176,658	134,459	125,677	120,843
Follow-Up Office Visits	All	1,718,679	1,698,550	1,742,278	1,758,715
Observation Services	Outpatient	15,799	20,648	19,750	18,956
Inpatient Visits	Inpatient	432,124	392,116	377,045	327,358
Office Consults	Office	66,099	76,147	76,662	85,523
Inpatient Consults	Inpatient	62,121	52,681	48,878	45,693
Confirmatory Consults	Office	566	916	735	666
ER Visits	Outpatient	550,361	371,881	361,624	381,886
Total		3,024,402	2,749,396	2,754,648	2,741,640

E. Community Care Services

The Community Care Unit within the Division of Medical Assistance is responsible for a range of support services intended to help persons whose acute health care needs require a high level of care that can be provided in a non-institutional, community-based setting. Community care services help patients remain at home and in the community, rather than being admitted as an inpatient to a hospital, nursing facility or ICF/MR. These services may also help a person transition from an acute inpatient level of care to a non-acute level. Community care services include:

- Home health;
- Personal care services;
- Home infusion therapy;
- Hospice; and
- Private duty nursing.

Community care services are of particular importance in the wake of the Supreme Court's 1999 Olmstead decision and the 1990 Americans with Disabilities Act (ADA). The ADA prohibits "the exclusion of an individual with a disability from participating in public programs or

receiving public benefits by reason of the person's disability." Department of Justice regulations implementing the ADA require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Department of Justice has stated that the "most integrated setting" standard applies to state Medicaid programs.

In L.C. By Zimring & E.W. v. Olmstead, patients in a state psychiatric hospital in Georgia filed suit challenging their placement in an institutional setting rather than in a community-based treatment program. Eventually, the Supreme Court held that the placement in an institutional setting violated the plaintiffs' ADA rights because it constituted a segregated environment.

All public programs, including state Medicaid programs, are now evaluating how to comply with the Olmstead decision to ensure that disabled individuals are able to be treated in the "most integrated setting"—generally, the community. Community care services are essential to ensure that persons who are in long term nursing or intermediate level care can safely be accommodated at home and in the community, instead of in an institution. While the Supreme Court clearly held that a state's duty is not boundless, and that it is not required to go faster than a "reasonable pace" for reforms, nationwide community care programs are getting new attention.

The careful implementation of these benefits is important for several reasons. First, following the Olmstead decision, these services are under a much higher level of scrutiny from the federal government, advocates, providers, and beneficiaries. Secondly, these services are difficult to define and manage on an individual level, as it is problematical to define prospectively exactly what level of care a patient may need, as well as challenging to monitor the delivery of services provided in a patient's home. Finally, many community care services are non-medical and cannot be evaluated against typical standards such as medical necessity.

DMA estimates that the addition of two home care nurse reviewers could improve oversight of medical necessity and allow for enforcement of any additional limitations identified to be cost beneficial. The estimated annual cost for these reviewers would be approximately $90,000, but DMA projects that potential savings of $500,000 per year could be achieved. These cost and savings estimates appear reasonable and the addition of these staff members would resolve some of the concerns discussed below.

1. Home health

Home health covers services necessary to help "restore, rehabilitate, or maintain a patient in the home" when "the patient's home is the most appropriate setting for the care." Home health services include skilled nursing, physical therapy, speech/language pathology, occupational therapy, home health aide services, and medical supplies. DMA's Community Care Manual, last updated October 2000, describes what specific services and supplies are included in each category, what qualifications are required of providers, and what circumstances qualify a patient to receive home health (see Appendix A for more detail).

WVMI's home health nurse reviewer found that the policies in the manual adequately describe the scope of services and medical necessity criteria. "Medical necessity" is documented by the physician who requests the service and compliance with the criteria is not reviewed by DMA,

except in the cases of women eligible for Medicaid solely due to pregnancy. In these cases the Medicaid fiscal agent authorizes only those home health services directly related to the pregnancy.

In addition, there are few fixed limitations on the amount or duration of these services. For example, skilled nursing/home health aide services can be provided up to seven days per week and up to eight hours per day, with a maximum of 24 hours per week; the only limitations are that skilled nursing visits to prefill insulin syringes or medication dispensers are limited to one per week. There are no limits on physical therapy, speech/language pathology, occupational therapy, or medical supplies.

Home health services are important services that allow patients who need services delivered in the home to receive the therapies and medical assistance needed to restore them to health. The breadth and depth of North Carolina's home health benefit testifies to the importance the state places on ensuring access for those who are often among the most disabled and vulnerable. It also constitutes a solid community-based benefit orientation, as envisioned by the ADA. However, these services are subject to overutilization and abuse, and the current limitations and oversight of this benefit in the North Carolina Medicaid program seems insufficient when compared to the controls used by the Medicare program and most other states.

A 1996 study by the General Accounting Office of the Medicare home health benefit found that "recent growth in the use of Medicare's home health benefit has largely resulted from 1989 HCFA guideline changes that made Medicare home health coverage criteria less restrictive, resulting in an increase in both the number of beneficiaries receiving services and the number of services received by each beneficiary." The GAO attributed these problems to the fact that "few home health claims are subject to medical review and most claims are paid without question...and physicians have limited involvement in home health care." [14] Consequently, the Medicare program instituted a variety of program limitations and enforcement strategies to minimize overutilization and abuse.

While it is important that Medicaid beneficiaries who need these services are able to access them appropriately, particularly in light of Olmstead, Medicare and many other states have found it necessary to create benefit limitations and oversight procedures to ensure program integrity. As shown in Exhibit III-8, other state Medicaid programs use a variety of "front-end" tools and methods to manage the use of Medicaid home health services, while North Carolina largely relies on post-payment reviews. The strategies used by other states include approval requirements for extended periods of service, prior approval requirements if the services are not in conjunction with a recent hospitalization, and specific limits on the type of services provided, such as nurse, therapy, or home health aide visits.[15] North Carolina could consider adopting some of these limitations to complement the reviews performed by Medical Policy and Program Integrity.

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[14] Medicare: Home Health Utilization Expands While Program Controls Deteriorate, General Accounting Office, March 1996.

[15] Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services, General Accounting Office, May 1999, GAO/HEHS-99-101

Also, as shown in Exhibit III-9, many states that place amount and duration limitations on the home health benefit have some kind of exception process to ensure that those beneficiaries who have appropriate medical reasons for exceeding the limits are able to receive necessary services. North Carolina could devise and implement similar exceptions or exemptions to continue to ensure access for those most in need.

Exhibit III-9. State Approaches towards Managing the Home Health Benefit

State	Limitation	Exceptions Process
Arkansas	50 skilled nursing and home health aide visits per state fiscal year	Benefit extensions available with prior authorization
Colorado	Prior authorization for home health needed for longer than 120 days	Prior authorization not required for Acute Home Health (less than 120 calendar days of service)
Florida	60 skilled nursing and home health visits per lifetime	Exceptions to the limit can be requested through a Medicaid contracted peer review agency
Kansas	6 months maximum; allowed only when rehabilitative, restorative and received within 6 months of accident or illness	
West Virginia	124 skilled nursing, social work, physical/speech/occupational therapy, and home health aide visits in a calendar year	After 124 visits patients are referred to case management services for review; prior authorization required for further services
North Carolina	No day or visit limits. Skilled nursing visits to pre-fill insulin syringes/medication dispensers limited to once per week. Prior approval only required for beneficiaries with Medicaid pregnant women coverage.	

2. *Personal care services*

The personal care services (PCS) benefit covers aide services to perform tasks for patients who have a medical condition that necessitates help with activities of daily living such as bathing, toileting, moving about, and keeping track of vital signs, as well as essential housekeeping and home management tasks. PCS is available in private residences and adult care homes. PCS is a paraprofessional service and does not include skilled nursing care, although some personal care services require a registered nurse aide. DMA's Community Care Manual describes the personal care services that are covered, the qualifications required of providers, and the circumstances that qualify a patient to receive PCS (see Appendix A for more detail).

Personal care services are authorized by a physician, who must sign off on a plan of care that indicates the days of the week the PCS aide is needed to provide care for the patient, the tasks to be performed by the PCS aide each day, and the estimated total time needed each day to accomplish the tasks assigned for that day. DMA limits personal care services to a total of 80 hours per month. Like other community care services, PCS for women eligible for Medicaid due to a pregnancy are limited to services directly related to the pregnancy.

States are allowed to set their own criteria for establishing who needs the PCS benefit and may use a wide variety of assessment instruments or other procedures to determine who receives services. In North Carolina, the home health agency that will provide the in-home PCS aides is generally responsible for assessing the patient's need for PCS and developing the plan of care that is then submitted to the patient's physician for approval. The agency must have a referral from a physician to begin the assessment. A nurse assessor must visit the patient in the home to determine the patient's current health status, needs, and other sources of assistance. If the nurse assessor determines that PCS is appropriate, the agency prepares a plan of care based on the assessment and sends the assessment and the plan of care to the physician. Neither the assessment nor the plan of care is reviewed on a prospective basis by the state, its fiscal agent/claims processor, or an outside reviewer.

Personal care services can be a cost-effective method to help Medicaid beneficiaries whose needs are broader than regular health needs (e.g., assistance with laundry, cleaning), particularly if the person's health status does not require a nursing level of care. However, because some personal care services are non-medical (although these services can only be provided coincident with health care services), nearly 20 states have chosen not to cover this optional Medicaid service. Some states treat PCS similarly to North Carolina; for example, California uses the PCS benefit as a means for providing personal care services to individuals with long-term care needs. However, Oregon targets this benefit toward an acute-care, more medically-based service. Some states limit PCS to persons with specific functional impairments, individuals with chronic or permanent disabilities, or children.

North Carolina's approach is consistent with its overall goal of providing access to care. It is also consistent with the state's desire to comply with Olmstead and the ADA. However, the inclusion of PCS in the benefit package – a benefit offered by only slightly more than half the states in the country – contributes to the state's overall budget numbers.

Given that North Carolina has chosen to provide broad access to these services, and that the state does not prospectively review medical appropriateness, it is important that the state have a method of verifying that services are delivered as authorized by the physician in order to ensure program integrity. However, the state's claims processing system does not currently have the capability to compare claims for PCS against the amount, duration, and scope of services authorized in the patient's individual plan of care on file with the physician.[16] Information on the number of hours authorized per day or the number of days authorized per week is not entered into the claims system, so there is no way for the processor to ensure that a given claim is in compliance with the physician approved plan of care. The claims system is only capable of ensuring that claims for PCS for a single patient do not exceed 80 hours per month. Therefore, any limits in the plan of care established by the physician lower than 80 hours cannot be enforced, and claims received by EDS will be paid (up to 80 hours per month).

In North Carolina, the process for approving personal care services and paying claims is largely dependent on the integrity of the home health agencies who conduct patient assessments, develop

[16] DMA is aware of this issue and is designing a new system that will be able to compare claims to client-specific limitations, but this system is not in place at the time of this writing.

plans of care, provider PCS, and submit bills. (Physicians are responsible for reviewing the plan of care and monitoring the delivery of services, but there is no way for the state to hold them accountable.) DMA should consider requiring an independent review by DMA staff or a contractor to the state to ensure that the plan of care is justified by the patient's condition, as it currently does for other Community Care section services such as private duty nursing. DMA should also investigate ways to monitor the delivery of personal care services on a retrospective basis by comparing claims to plans of care.

Recommendation

✓ Improve process for reviewing the delivery of personal care services through additional prior authorization of services, concurrent review of service delivery, or post-payment review

3. *Private duty nursing*

Private duty nursing or "PDN" is continuous, substantial, and complex nursing services performed by a licensed nurse (RN or LPN) in the patient's home. PDN can also be provided outside of the home when the patient's "normal life activities" (e.g., a child attending school) take the patient away from the home during the day (see Appendix A for more detail).

Private duty nursing is a very expensive service—at current Medicaid rates, costs can range from $5,000 to $20,000 a month to maintain a patient in his/her home. Private duty nursing services require prior approval, which is performed by the Home Care Initiatives (HCI) staff at DMA. The initial prior approval process is similar to the process for personal care services: the agency that will provide the private duty nurses assesses the patient's need for PDN and completes a referral form which is sent, along with the original physician's request letter and any other clinical information, to the HCI unit for approval. The HCI Unit determines whether services are needed or if an additional visit (by HCI Unit staff) is needed to assess appropriateness. If services are approved, the HCI Unit determines the number of hours per day and the number of days per week that services are approved, as well as the starting and ending dates of the approval period (generally a 30- to 60-day period). A similar process is used to reassess patients who request services beyond the initial approval period.

Unlike personal care services, PDN is closely monitored by the HCI Unit. HCI Unit nurses review individual patient information prior to approving or reapproving PDN services, and may conduct home visits to assess a patient's need if the information provided by the physician or nursing agency is insufficient to justify the request. Private duty nurses are required to keep nursing notes to document all activities to substantiate that all care is provided in accordance with the doctor's orders and HCI Unit's approval. This documentation is periodically reviewed by the HCI Unit staff. In general, administration of the PDN benefit is well designed and well enforced.

Despite the additional level of scrutiny provided for these services, compared to some other Community Care services, senior nurse reviewers at WVMI noted discrete deficiencies in the medically necessary and utilization review criteria. For example, conditions which exhibit medical necessity often differ for adult and pediatric patients, but North Carolina does not appear to distinguish between the two in its published policies. The PDN section of the Community Care Manual lists under "Medical Needs of the Patient" (the section defining medical necessity) three "cases that may require PDN" but notes that the list is not all-inclusive. The "Getting

Coverage" section of the manual lists the criteria that an assessor should follow to determine need for PDN, but these are not detailed or specific to given PDN services, nor do they describe circumstances for exceptions or exclusions.

Recommendation	
WVMI recommends the adoption and usage of much more specific criteria, such as the following:	
Example in NC Manual	**More Specific Criteria***
A patient requires prolonged intravenous nutrition or drug therapy with needs beyond those covered by Home Infusion Therapy services.	Intravenous infusions, including Total Parenteral Nutrition (TPN), medications, and fluids: For an adult client receiving intravenous infusions, there may or may not be medical need for Private Duty Nursing. Any adult client who is receiving intravenous infusions, but is not on mechanical ventilation or being weaned from mechanical ventilation, will be automatically referred to a PRO Physician Reviewer for an individual determination of medical need for Private Duty Nursing. The Physician Reviewer will take into account combinations of technologies and co-morbidities when making this determination.
A patient depends on a ventilator for prolonged periods.	Mechanical ventilation: The adult client has medical need for Private Duty Nursing during the hours spent on the ventilator. Weaning from mechanical ventilation: The adult client has medical need for Private Duty Nursing for ventilator weaning during the hours necessary to stabilize the client's condition. Stable condition will be evidenced by ability to clear secretions, vital signs stable, blood gases stable with oxygen greater than 92%, and pulse oximetry greater than 92%.
A patient depends on other device-based respiratory support, including tracheostomy care and tracheal suctioning.	Tracheostomy: The pediatric client has medical need for Private Duty Nursing during all hours that the client has a tracheostomy. Tracheostomy decannulation: The pediatric client has medical need for Private Duty Nursing after tracheostomy decannulation during the hours necessary to stabilize the client's condition. Stable condition will be evidenced by ability to clear secretions, not using auxiliary muscles for breathing, vital signs stable, blood gases stable with oxygen greater than 92%, and pulse oximetry greater than 92%.

**These sample criteria were developed by WVMI staff based on language used by the West Virginia, Oregon, and Colorado Medicaid programs.*

Providers are instructed by DMA not to bill for certain other similar services listed in the provider manual (e.g., hospice, personal care services, or home infusion therapy) provided at the same time of day as PDN. However, there is no field on the UB-92 claims submission form to indicate time of day a service is provided. Therefore, there is no way for the claims system to recognize when services are provided at the same time of day and reject inappropriate claims. This is an example of a policy that is not being enforced by the claims payment system. Since this information is not available on the claim form, it is difficult for the Program Integrity Unit to perform other post-payment review. Only comparison on nursing notes from the time of delivery may indicate whether duplicate services were provided simultaneously, and this review would be extremely time consuming and likely subject to error. DMA should consider alternative methods for enforcing this policy or change the policy to reflect circumstances that can be enforced.

F. Community Alternatives Programs

DMA operates four "Community Alternatives Programs" with special permission from the federal Department of Health and Human Services under Medicaid waivers. The CAPs, also known as "home and community-based waiver service" programs, are intended to allow the state to provide a high level of community support so that Medicaid beneficiaries who would otherwise be required to live in nursing homes or ICF/MRs are able to continue living in their homes and communities. The four programs are:[17]

1. CAP for Disabled Adults (CAP/DA): The program is available in all North Carolina counties and served approximately 12,000 people in SFY 1999.

2. CAP for Children (CAP/C): provides cost-effective home care for medically fragile children (through age 18) who would otherwise require long-term hospital care or nursing facility care. Over 200 children participated in CAP/C in SFY 1999.

3. CAP for Persons with AIDS (CAP/AIDS): CAP/AIDS is a cooperative effort with the Division of Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. Approximately 40 people were served in SFY 1999.

4. CAP for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD): The Division of Mental Health, Developmental Disabilities and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. CAP-MR/DD served approximately 4,000 people in SFY 1999.

States are not limited in the scope of services they can provide under such home and community-based services programs so long as they are cost effective compared to the institutional long term care alternative (i.e., the nursing home or ICF/MR). Therefore, the services and support CAP participants receive are greater than those provided to other Medicaid beneficiaries, even other beneficiaries who are receiving PCS or PDN. These extra services can include a case manager to coordinate the person's medical care, home management assistance (e.g., assistance in developing budgets and planning meals), personal care services (e.g., assistance with hygiene, eating, toileting), in-home aide services (e.g., administer treatments, take medical samples, clean and treat wounds); skilled nursing services in the home; "waiver supplies" (e.g., incontinence undergarments, nutritional supplements); and home mobility aids (e.g., wheelchair ramps, safety rails). See Appendix A for more detail on each of the programs. All of the Community Alternatives programs have demonstrated substantial savings compared to the equivalent cost of keeping CAP participants in nursing homes or ICF/MRs.

In order to obtain CAP services, a Medicaid beneficiary must have a plan of care developed by a case manager at an approved local agency (e.g., local Department of Social Services or county health department, Area Mental Health Center, or the AIDS Care Unit). The treatment plan will contain approval for a specific amount, duration, and scope of services that are available in that program (services differ between the four programs). Services are typically provided by local

[17] Special Programs, North Carolina Division of Medical Assistance, February 17, 2000.

home health and nursing agencies, and must be specifically authorized by the patient's case manager based on the plan of care.

CAP service providers are required to submit claims to the case manager for review and approval before submission to the state's claims processor. However, the claims processor does not verify case manager sign-off, so service providers may be paid for non-approved services that will only be identified through a retrospective comparison of claims to case manager approval records. Again, the claims payment system cannot compare claims to client-specific limits in individual patient plans of care, but a planned redesign of the claims processing system should have this capability. In the meantime, claims submitted without case manager sign-off are subject to recoupment, but post-payment review is more expensive and less effective at identifying unapproved services than system edits that would check for case manager sign-off at the time of claims submission.

Another challenge to program integrity is in the inability of the claims processing system to support certain service restrictions. The CAP provider manual defines many situations in which providers should not bill for duplicate services. For example, CAP/DA providers offering in-home aide services are instructed not to bill for these services if the patient receives a "substantially equivalent" regular (i.e., non-CAP) Medicaid service the same day, such as personal care services. However, the system cannot interpret claims to determine whether two same day claims are "substantially equivalent"—the specific services subject to this limitation must be programmed into the system or it cannot enforce this policy. Likewise, CAP/DA providers are instructed not to bill for in-home aide services provided at the same time of day as home health services. Since there is no field on the claim form to indicate what time of day a service is provided, there is no way for the claims system to identify concurrent services and reject the inappropriate claim. Exhibit III-10 summarizes which CAP service restrictions can and cannot be supported by the claims processing system.

Exhibit III-10. Ability of the claims processing system to support CAP service policies

CAP	CAP Service	Restrictions on other services	Supported in claims system?
CAP/ Children	All CAP/C services	Cannot bill for CAP/C service if the patient is in a hospital, nursing facility, or ICF/MR	Yes, there is an audit to identify services provided on the same day
CAP/ Children	CAP/C Personal care services	Cannot bill for CAP/C service on the same day as a regular Medicaid personal care services or home health aide services	Yes, there is an audit to identify services provided on the same day
CAP/ Disabled Adults	All CAP/C services	Cannot bill for CAP/C service if the patient is in a hospital, nursing facility, or ICF/MR	Yes, there is an audit to identify services provided on the same day
CAP-MR/DD	All CAP-MR/DD services	Cannot bill for CAP-MR/DD service if the patient is in a hospital, nursing facility, or ICF/MR	Yes, there is an audit to identify services provided on the same day
CAP-MR/DD	All CAP-MR/DD services	Cannot bill for CAP-MR/DD service during the hours a child is attending a public school	No, there is no way to identify whether time and date of service provision coincides with school hours

CAP	CAP Service	Restrictions on other services	Supported in claims system?
CAP-MR/DD	Most CAP-MR/DD services	Cannot bill for more than one CAP-MR/DD service provided on the same day or same time of day	Yes and no, there is an audit to identify services provided on the same day but there is no way to identify services provided at the same time of day
CAP/ AIDS	All CAP-MR/DD services	Cannot bill for CAP/AIDS service if the patient is in a hospital, nursing facility, or ICF/MR	Yes, there is an audit to identify services provided on the same day
CAP/ AIDS	CAP/AIDS Adult day health care	Cannot bill for CAP/AIDS service at the same time of day as CAP/AIDS in-home aide services or respite care or regular Medicaid personal care services	No, there is no way to identify services provided at the same time of day

The inability of the claims system to support these policies renders them effectively meaningless—it is very easy for providers to ignore the rules, and difficult for DMA to detect or correct abuse. These restrictions might be better supported by manual reviews by experienced reviewers who could examine individual cases to ensure that services are delivered as intended.

G. Behavioral Health

Behavioral health benefits in the North Carolina Medicaid program include:

- Inpatient care at a psychiatric hospital for children under 21 and adults over 65;
- Up to 24 visits per year to a private practice psychiatrist, physician, or PhD and MA psychologist employed and supervised by a physician for adults,[18] unlimited number for children under 21;
- Unlimited outpatient visits per year (psychiatrist, psychologist, social worker, or counselor visits; day treatment or partial hospitalization; emergency services) provided at a public Area Mental Health Center for adults and children;
- ICF/MR services for adults and children;
- Case management for emotionally disturbed youth; and
- Residential treatment for children under 21.

The Medicaid behavioral health benefits package was developed in close consultation with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). DMA and DMH/DD/SAS have a Memorandum of Agreement under which DMH/DD/SAS oversees the provision of most Medicaid behavioral health services. The main points of entry into the behavioral health system are the state's 39 Area Mental Health Authorities ("Area Programs"), which are part of DMH/DD/SAS's service network. Patients that have a plan of treatment, developed by and on file with an Area Program, are offered outpatient

[18] Adult visits to private practice psychiatrists count towards the annual 24 physician visit limit (behavioral health specialists are treated the same as physical health providers).

mental health services, partial hospitalization, and emergency services through that center. These services do not come under the visit limit on service provided outside of the Area Program.

WVMI's reviewing psychiatrist found that the levels of service for the various outpatient services and levels of residential treatment for children are well-defined in the behavioral health provider manuals. Likewise, the assessment tools used to evaluate a patient's condition are sufficient to determine medical necessity. Many of the criteria used to determine medical necessity are similar to or based on nationally-recognized criteria such as those used by the American Academy of Child Psychiatry, the American Psychiatric Association, and the American Society of Addiction Medicine (for substance abuse services). These criteria are commonly used throughout the industry. In this respect, the behavioral services are well designed and well-defined.

The range of behavioral health services covered by the North Carolina Medicaid program is very broad compared to some other states, which may either not cover some services or provide them through state agencies not associated with Medicaid. The behavioral health benefit includes a wide range of "ancillary" outpatient services such as psychoeducational activities, in-home services, community integration activities, behavioral interventions, and supportive counseling (see Appendix A for more detail on specific behavioral health benefits). This is another example of DMA's expansive benefit package under the rubric of defining the "amount, duration, and scope" of a benefit broadly.

Public providers, especially the Area Programs, enjoy several advantages when compared to private providers. The strong preference demonstrated in the behavioral health benefit package for services provided by Area Programs over those provided by private practitioners stems in part from the state's interest in maximizing federal revenue to public Area Programs. This contributes to a strong safety net and supports the Area Programs' ability to provide services to non-Medicaid-eligible persons in North Carolina. At the same time, it contributes to an uneven playing field that may discourage private provider participation in Medicaid's behavioral health benefit. For example:

- Area Programs review and approve Levels I and 2 residential stays without input from ValueOptions (see below), thus influencing those private residential providers to work with Area Programs;

- Area Programs retain the sole utilization management role for non-medical enrolled private residential providers, meaning private providers must contract with Area Programs to avoid scrutiny by DMA's utilization management contractor;

- Only Area Programs authorize admissions to independent residential providers, even from a private doctor to a private residential provider, again locking in their role and requiring private providers (who are *competing* with Area Programs) to secure favorable relationships with Area Programs; and

- Outpatient visits at Area Programs are not subject to annual limits, while outpatient visits to private providers are.

WVMI's psychiatric expert noted one potential clinical area for improvement: early psychiatrist or physician involvement in treatment planning. Area Programs assess new patients using a variety of diagnostic criteria, and develop treatment plans based on those assessments. However, there is currently no requirement for an early assessment by a psychiatrist or physician to identify any biological basis for mental illness that might respond to medication or rule out diseases that might cause symptoms of mental illness, such as thyroid disorder. Without this medical assessment, a patient might receive a large number of non-medical therapy visits without improvement. A physician assessment early in the treatment process—after four visits, for example—could lead to more clinically appropriate care and possibly reduce utilization of less successful forms of treatment for that patient.

Another concern is that the division of utilization management responsibilities among so many different organizations may compromise continuity of care. Currently, four different organizations are responsible for reviewing and prior authorizing different elements of the behavioral health service package:

- Area Programs: prior authorization for Levels II-IV residential treatment for children
- EDS: prior authorization for private practitioner outpatient visits for adults after the second visit, prior authorization for placement in an intermediate care facility for the mentally retarded (ICF/MR)
- First Health: prior authorization for Psychiatric Residential Treatment Facility (PRTF) placement for children
- Value Options: prior authorization for outpatient visits for children after the 26th visit

Two potential disruptions to continuity of care may arise from this division of responsibilities between multiple contractors. First, having different organizations authorize care for the same patient at different places along a single continuum of care can create communication problems and delays in obtaining authorization. For example, Area Programs authorize Level IV residential treatment for children, while First Health authorizes the level above Level IV–Psychiatric Residential Treatment Facility placement. If these two organizations interpret the placement criteria differently, or reach different conclusions based on a patient's diagnostic assessment, there is potential for benefit overlaps and "turf" issues. DMA has a process that requires the vendors to notify DMA of a difference of opinion before a denial is issued, so that agency staff can intervene and help resolve the issue. This helps prevent patients from "falling between the cracks" but adds an additional step—and time—to the prior authorization process. Second, this multi-vendor system adds a layer of complexity that may make it more difficult for primary care physicians to coordinate a patient's physician and behavioral health care, or even determine whom to contact to find out information on a patient's current status.

IV. COMPARISONS TO SELECTED STATES AND INSURERS

The challenges in managing a comprehensive health benefits plan are not unique to the North Carolina Medicaid program—private insurers and other state Medicaid programs are also contending with rapidly rising health care costs, increasingly complex billing and claims procedures, and utilization management pressures. This chapter examines some of the approaches used by other Medicaid programs and private insurers that could be adopted by the North Carolina Medicaid program, and notes where DMA is ahead of the curve or in line with other payers.

The Lewin Group surveyed 10 state Medicaid programs and four North Carolina private insurers for this engagement. State survey questions focused on key health benefits and program management concerns. Private insurer questions focused on benefits delivery in North Carolina, utilization management procedures, and policy development. Copies of the survey instruments are included in Appendix I.

In the discussion below, we recognize that not all circumstances are directly relevant to North Carolina Medicaid. States have a great deal of flexibility in how they choose to manage their Medicaid programs and may make decisions and use approaches that do not translate well to North Carolina. Private insurers use a wide variety of techniques to develop and manage their health benefits, not all of which are allowed in public sector programs such as Medicaid. Nevertheless, we have identified many important lessons that can be used by DMA as the basis for framing new approaches to North Carolina's challenges.

A. States Use Many Approaches to Manage the Amount, Duration and Scope of Services

Two specific benefits are discussed below: prescription drugs and long term care. These two are highlighted for review because of their relative importance in terms of the amount of spending and number of beneficiaries affected, as well as the complexity in managing these benefits. We also review several states' primary care case management (PCCM) programs. Nearly 73 percent of North Carolina's Medicaid beneficiaries are enrolled in a PCCM program, Carolina ACCESS, so PCCM issues have great relevance for the North Carolina program.

It should also be noted that we conducted a survey of other states' behavioral health programs in Medicaid. We chose not to include a discussion below on behavioral health, due to the extreme apples-and-oranges problem we found in our survey results: states simply vary too much to draw clean comparisons.

1. Prescription drugs

Although coverage of prescription drugs is an optional Medicaid benefit, all 50 states and the District of Columbia provide this benefit. Medicaid pharmacy policy can be set by individual state Medicaid programs within broad guidelines developed by the federal government. Among these guidelines are those created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which require state Medicaid pharmacy programs to develop and implement prospective and retrospective drug utilization review (DUR) programs. This legislation also requires mandatory

manufacturer rebates, coverage for newly FDA-approved drugs, and an elimination of restrictive drug formularies. Outside of these requirements, states have a great degree of flexibility in how tightly they manage their Medicaid pharmaceutical programs in order to balance the goal of assuring that prescriptions are appropriate and medically necessary while they manage costs.

As prescription drug costs rise at an alarming rate (Medicaid prescription drug payments rose by 13 percent nationally from 1997 to 1998[1]), states are adopting cost management approaches used by the private sector and their peers in Medicaid programs across the country. These approaches include prior authorization and other limits on access, policies to encourage the use of generic medication forms, identifying new strategies to contain costs, and greater use of clinical consultants in forming prescription drug coverage policy. For the purposes of identifying and highlighting alternative practices in Medicaid pharmaceutical programs we selected the following five states to interview: Arkansas, Florida, Georgia, Oklahoma, and Oregon.

Exhibit IV-1. Pharmacy Management Practices Used by Five States

State	Prior Authorization	Other Limits on Access	Policies to Encourage Use of Generics	Identify New Strategies to Contain Costs	Active and Involved DUR Board
Arkansas	✓	✓	✓	✓	
Florida	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	
Oklahoma	✓	✓	✓	✓	✓
Oregon	✓	✓		✓	✓
North Carolina		✓			

a) Prior authorization

All five of the states we interviewed have contracted with an independent organization to develop and implement prior authorization procedures. The majority of the five states interviewed require prior authorization of the following types of drugs: antihistamines, anti-ulcer drugs, anti-inflammatories or NSAIDs, growth hormones, lipase inhibitors or weight loss medications, and pain relievers.

Prior authorization processes can create a barrier to access if the process creates substantial delays in obtaining needed medications. States and their contractors can structure prior authorization procedures to minimize the time needed for review and approval. For example, in Arkansas physicians fill out and sign a prior authorization form for each prescription and send it to the pharmacist. The state's contracted entity to oversee prior authorization, has an automated voice response system that allows pharmacists to obtain prior authorization 24 hours a day seven days a week, and a help desk staffed with pharmacy benefits specialists available during typical business hours to expedite the handling of unusual claims.

[1] National Pharmaceutical Council. (1999). Pharmaceutical Benefits Under State Medical Assistance Programs.

b) Generic vs. brand name limitations

The promotion and use of generic drugs in lieu of brand name drugs has the potential to save states a great deal of money. North Carolina's policy notes this by requiring generic substitution when appropriate. The five states we surveyed implemented varying policies to encourage generic drug use. The majority of the states at the very least implemented a differential prior authorization or dispensing fee for generics. For example, Florida's four brand name drug limit does not apply to generics. This is a more targeted approach to prescription limits than North Carolina uses, where the six prescription limit does not distinguish between brand name and generic medications. Arkansas, which boasts a 59 percent generic drug utilization rate, only authorizes brand name drugs with a generic equivalent to be dispensed if the brand name drug is medically necessary. Georgia has a number of policies under review and development, including profiling and educating providers, increasing the generic or preferred drug dispensing fee by $0.50 over the dispensing fee for brand name drugs, and requiring differential prior authorization for brand name drugs. While most states allow pharmacists to substitute generics for brand name drugs, Oklahoma and Oregon require pharmacists to substitute generic medications unless the prescribing provider certifies that the brand is medically necessary.

c) Other limitations

In addition to prior authorization and limitations on brand name drugs, states can choose from a number of other utilization management techniques that can help contain costs while ensuring access to necessary care. Prescriptions can be limited by the number of days and/or doses that can be supplied at one time: all five states interviewed impose supply limits ranging from 31 to 34 days. Some states require evidence of failed past treatment with generics or over-the-counter medication before certain brand name drugs can be dispensed. Four of five states we interviewed authorize pharmacists to dispense selected drugs only if the patient presented with a specific diagnosis. The same four states also limit the number of prescriptions each beneficiary can receive per month. Florida further restricts prescriptions to four brand name drugs per month for all Medicaid beneficiaries over 21 not in long term care.

Exhibit IV-2. Summary Of Limitations On Prescription Drug Benefits

	Arkansas	Florida	Georgia	Oklahoma	Oregon	North Carolina
Drug Type	**Drug Category Specific Limitations**					
Antidepressants		Day limit Dose limit Prior approval				
Antihistamines	Day limit Prior treatment Prior approval		Day limit Prior approval	Prior treatment Prior approval	Day limit Diagnosis Prior approval	
Anti-ulcer	Day limit Diagnosis Prior approval	Day limit Dose limit Prior treatment Prior approval	Dose limit Prior approval	Day limit Diagnosis Prior approval	Day limit Dose limit Prior approval	

	Arkansas	Florida	Georgia	Oklahoma	Oregon	North Carolina
Drug Type	**Drug Category Specific Limitations**					
Cardiovascular			Prior approval			
Cox-2 Inhibitors	Day limit Prior treatment Prior approval					
Dermatologicals					Prior approval	
Growth Hormones		Day limit Prior approval	Prior approval	Diagnosis Prior approval	Prior approval	Prior approval *Serostim*
Impotence	Day limit Dose limit Prior approval		Prior approval			Prior approval *Viagra, Caverject, Muse*
Lipase Inhibitors Weight Loss	Day limit Dose limit Prior approval	Prior approval	Prior approval		Day limit Diagnosis Prior approval	Prior approval *Meridia*
NSAIDs	Day limit Prior treatment Prior approval		Prior approval	Diagnosis Prior approval		
Pain	Day limit Dose limit Prior approval		Day limit Prior approval	Day limit Dose limit Prior approval		
Limitation	**Other Limitations**					
Maximum number of days	31 days	34 days	31 days	34 days	34 days	100 days
Maximum number of prescriptions per month*	3 *children exempt*	4 (brand name limit) *children exempt*	5 (adults) 6 (children)	3 *children exempt*	Unlimited	6
Specific diagnosis required	Yes	Yes	Yes	Yes	No	Yes
Policies encouraging use of generics	Yes	Yes	Under considera-tion	Yes	Yes	Yes
Policies requiring use of generics	Yes	No	No	Yes	Yes	Yes

* Some states, including North Carolina, have an exemption process so that in some circumstances beneficiaries can obtain more than usual maximum number of prescriptions allowed.

d) Identifying new strategies to contain costs

The five states interviewed rely on an array of utilization management procedures to control rising prescription drug costs. However, some states are finding that they need to expand their cost management strategies as they continue to see prescription drug expenditures rise. Arkansas is in the process of having pharmacists complete a Cost of Dispensing Survey and an Acquisition Cost Survey. Currently, prior authorization is the state's only tool to limit the use of certain medications that may be misused, abused, or over-prescribed. Arkansas believes the survey will identify areas that will benefit from cost management measures.

Potential Strategies to Contain Drug Costs

Limit on days/dose prescribed
Selected drug therapy limits
Generic drug manufacturer rebate increase
Patient profiles to pharmacies/physicians
Limit on number of brand name prescriptions
Appointment of Medicaid Pharmacy and Therapeutics committee
Accelerated collection of past due rebates
Early refill limit
Voluntary preferred drug list
Edit day supplies/volume
Prescriber prior authorization
Diabetic supply mail order contract
Restriction ("lock-in") to a single pharmacy
Prescriber pattern review

Some states have come to the conclusion that a prior authorization process alone cannot sufficiently contain prescription drug costs, so they are investigating and developing supplemental cost management procedures. On October 1, 2000 Georgia contracted with a pharmacy benefit manager to provide a range of pharmacy benefit management services (the program is currently in the implementation phase). Oregon is considering a number of drug spending controls such as requiring pharmacy lock-in (i.e., mandating that beneficiaries obtain all their drugs from a single pharmacy), reducing dispensing and ingredient fees, and implementing an academic detailing program for prescribers utilizing "best practice drug treatment guidelines."

e) DUR Board activities

Another requirement of OBRA '90 is that states establish Drug Utilization Review (DUR) Boards to oversee prospective and retrospective drug utilization review. DUR boards must at minimum function as a recommending body. Some states have opted to have their DUR Boards play a more central role in their prescription drug program. For example, Florida's DUR Board consists of ten voting members and meets quarterly. The DUR Board is responsible for preparing an annual report and is required to work closely with the Medicaid Prescribing Pattern Review Panel. In addition, Florida recently implemented a Therapeutic Academic Intervention Program where staff pharmacists perform interventions in the offices of prescribers who have been identified by the Medicaid agency as exhibiting patterns of excessive, abusive, or inappropriate use of drug therapies. In Oregon the DUR Board is required to publish and disseminate educational information to prescribers and pharmacists in addition to its duties advising the Office of Medical Assistance Programs (OMAP) on the implementation of prospective and retrospective DUR. Although the DUR Board status is only that of a recommending body, OMAP management approves most of its suggestions for drug utilization review.

f) Lessons for North Carolina

North Carolina can fine-tune its Medicaid pharmaceutical program by adopting some of the practices identified in other states' programs. As evidenced above, states are using a variety of innovative approaches borrowed from their peers across state and industry lines. North Carolina Medicaid's open formulary coupled with the lack of a rigorous prior authorization process fails to address the critical issue of cost management. Although North Carolina requires prior authorization of a couple of expensive drugs like Viagra and Xenical, the procedure is limited to only six drugs.

Recommendations

- ✓ Expand prior authorization program to include brand name drugs when generics are available (i.e., limit ability of pharmacists to override this requirement at the point-of-sale);
- ✓ Limit access to certain drugs to patients who present with a specific diagnosis;
- ✓ Evaluate other incentives to encourage use of generic drugs, such as differential dispensing fees or differential copayments;
- ✓ Actively manage physician prescribing practices through provider profiling;
- ✓ Contract with a pharmacy benefits manager to implement more extensive prospective drug utilization review; and
- ✓ Decrease 100-day supplies to 34-day supplies for some or all drugs.

2. Long-term care

Traditionally, long-term care services have been provided in an institutional setting, such as a skilled nursing facility (SNF), an intermediate care facility (ICF), or an intermediate care facility for the mentally retarded (ICF/MR). These facilities are designed to accommodate patients who required daily care (but not hospital-level care) for an extended period. However, the cost of providing these services is very high, and institutional placement keeps patients away from home and family.

While facility-based care remains an important part of most states' long-term care capacity, many states have developed "home and community-based services" programs. These programs enable Medicaid beneficiaries with high levels of need to receive enabling services that help them remain in their homes and communities. In North Carolina, these programs are called Community Alternatives Programs (CAPs).[2] Interest in these programs has increased nationwide following the Olmstead court decision (discussed in Chapter III), which requires state Medicaid

[2] As discussed in more detail in Chapter III, North Carolina has CAPs for persons in four groups who would otherwise need full-time institutional care: disabled adults, children, persons with mental retardation or developmental disabilities, and persons with HIV/AIDS.

programs to ensure that disabled individuals are able to be treated in the "most integrated setting"—generally, the community.

A special feature of these programs is that states can spend approximately as much as it would cost to pay for nursing care to cover a broad range of community-based services. This enables states to cover some high-cost services for a subset of Medicaid beneficiaries—those who would otherwise need expensive long-term care—without breaking the Medicaid budget by providing the services to all beneficiaries. The federal government limits how many beneficiaries can participate in these programs in each state.

Like North Carolina, the three states interviewed all place a heavy emphasis on community-based care. Oregon and New Hampshire strongly promote home- and community-based services as an alternative to long-term nursing care. Pennsylvania was recently awarded a Nursing Homes Transition Grant by HCFA that will enable the state to "dramatically" increase the number of elderly beneficiaries who can enroll in community-based care programs. A comparison of the types of home and community-based services offered by the states we surveyed is provided in Exhibit IV-3. (Note that some states provide certain of these services to all Medicaid beneficiaries, regardless of enrollment in a home and community-based services program. For example, North Carolina provides adult care home services, home health, private duty nursing, case management, home infusion therapy, and personal care services to all Medicaid beneficiaries.)

Exhibit IV-3. Home and Community-Based Services Coverage

Services	OR	NH	PA	NC
Adult Foster Homes	√			
Assisted Living Facilities/Adult Care Homes	√		√	√
Home Health Care			√	√
Respite Care	√	√	√	√
Private Duty Nursing			√	√
Homemaker Services	√	√	√	
Adult Day Care	√	√	√	√
Environmental Modifications	√	√	√	√
Chore Services	√			
Personal Emergency Response System	√	√	√	√
Home Delivered Meals	√		√	√
Nutritional Counseling & Supplements			√	√
Transportation	√		√	
Vehicular Modifications			√	
Attendant Care	√		√	√
Companion Services	√		√	
Case Management	√	√	√	√
Personal Care Services	√	√	√	√
Assistive Technology Support/Home Infusion Therapy		√	√	√

A significant way in which North Carolina differs from the other states surveyed is the process for enrolling beneficiaries in institutional long-term care or community-based care. In North Carolina, utilization review contractors determine whether a beneficiary requires skilled nursing or intermediate-level care. However, the contractors who make these determinations do not refer eligible beneficiaries to the appropriate CAP; enrollment in Community Alternatives is a separate process. This disconnect between the two options may result in some beneficiaries not realizing that they have an alternative to institutional care. The three states we surveyed all link the two processes so that beneficiaries who qualify for long-term care can choose between institutional care and home and community-based care (to the extent either option is available in their area). We recommend that North Carolina coordinate these processes.

Recommendation

✓ Coordinate the processes for determining eligibility for institutional care and enrolling in a CAP.

3. *Primary care case management*

The primary care case management (PCCM) concept in Medicaid was created to improve continuity of care over the traditional "fee-for-service" program, in which beneficiaries were required to locate providers who would accept Medicaid and try to determine for themselves when they needed care and what level of care to obtain. PCCM programs link each beneficiary with a primary care provider, such as an internist, pediatrician, or OB/GYN, who will provide a "medical home" for the beneficiary. In most PCCM programs, the primary care provider is responsible for:

- Being available to provide primary care and after-hours consultation on urgent or emergent conditions;
- Reviewing the beneficiary's need for certain services (e.g., specialty physician care) and providing authorization for the beneficiary to obtain these services if appropriate; and
- Helping to coordinate specialty or hospital care if needed.

Providers must agree to perform these "case management" duties, which vary from state to state, in exchange for which they are compensated for the additional responsibilities associated with approving and coordinating care—usually a small fee per month (e.g., $3.00) for each beneficiary assigned to that provider, on top of what the provider receives for direct care delivered to his/her patients.

North Carolina has an extensive PCCM known as "Carolina ACCESS." It has three variations, which are discussed below.

PCCM programs are intended to be cost-neutral: that is, the cost of the case management fees to the primary care providers is offset by savings from providing better primary care and therefore preventing some serious conditions, reducing emergency room usage by giving patients after-hours access to a doctor, and reducing inpatient costs by improving coordination and continuity of care. For example, since the implementation of its PCCM program in 1993, Georgia reports an increase of approximately 4 percent in primary care office visits, a decrease of approximately 11

percent in specialty care visits, and a decrease in emergency room use of approximately 24 percent.

Most Medicaid programs now have PCCM in at least part of their state; in some states, including North Carolina, PCCM is available statewide and enrolls the majority of Medicaid beneficiaries.

The remainder of this section compares North Carolina's PCCM program, Carolina ACCESS, to PCCM programs in five other states: Arkansas, Georgia, Massachusetts, Oklahoma, and Texas. Key areas for comparison include the referral/prior authorization process, provider profiling, and special financial arrangements, as shown in Exhibit IV-4.

Exhibit IV-4. PCCM Program Strategies

State	Referrals/ Prior Authorization	Provider Profiling	Special Financial Arrangements
AR	√	√	√
GA	√	√	
MA	√	√	√
OK	√	planned	√
TX	√	√	
NC	√	√	

a) Referral and prior authorization requirements

As shown in Exhibit IV-4, all PCCM programs surveyed require primary care providers to manage their patients' utilization by providing referrals to certain types of providers, e.g., specialist physicians, hospitals, and home health. The range of services that require primary care provider pre-approval varies from state to state—some Medicaid programs use the PCCM program to manage utilization by requiring primary care providers to act as a "gatekeeper" for most services.[3] Other states may allow Medicaid beneficiaries to access many Medicaid services without getting approval from the primary care provider first. North Carolina and the other states surveyed require primary care provider pre-approval for the services checked in Exhibit IV-5.[4]

Exhibit IV-5. Services Requiring Primary Care Provider Pre-approval.

Service	AR	GA	MA	TX	NC
Dental care					
Durable medical equipment	√	√	√	√	√
Home health	√	√	√	√	√
Inpatient hospital	√	√	√	√	√

[3] In most PCCM programs, services that normally require prior approval by the Medicaid agency or a utilization review contractor will still require the beneficiary to obtain this approval, whether or not the service must also be pre-approved by the primary care provider.

[4] Information on Oklahoma was not available.

Service	AR	GA	MA	TX	NC
Inpatient psychiatric care					
Lab and X-ray	√	√	√	√	
Nursing facility				√	
Physical/speech/occupational therapy	√	√	√	√	√
Podiatry	√		√	√	√
Prescription drugs					
Private duty nursing	√	√	√	√	√
Specialist physician	√	√	√	√	√

In North Carolina, the referral process operates as follows: if a primary care provider determines that one of his or her patients needs specialist services, the provider gives the patient a referral number (usually the primary care provider's Medicaid ID number or other standard identifier) to give to the specialist provider. The specialist provider must enter this referral number onto the claim for it to be paid by Medicaid. Other PCCM programs use a similar approach; Arkansas has an optional form that providers can use. Primary care providers are expected to document referrals in patients' medical records.

Many states, including North Carolina, produce periodic reports indicating what referral services were provided for which patients. primary care providers can compare these reports to patients' medical records to verify that their patients received the services that had been pre-approved, and determine if their provider number is being used for services that were not appropriately referred. Oklahoma conducts external audits of PCCM medical records to ensure that providers are accurately documenting referrals and obtaining information from the referral providers.

b) Provider profiling

Since each provider in a PCCM program has a consistent set of responsibilities and expectations, state Medicaid programs can develop "provider profiles" that compare an individual provider's practice patterns to other PCCM providers. Some of the categories that may be profiled on these reports are:

- Average number of primary care and specialty care visits per assigned beneficiary;
- Percentage of children who received well child visits or Health Check/EPSDT screens;
- Emergency room usage;
- Inpatient utilization (e.g., bed days, discharges, average length of stay);
- Number of prescription filled per assigned beneficiary; and/or
- Total cost of various services (e.g., physician visits, hospital, pharmacy) provided to assigned beneficiaries.

Some states, such as Georgia, Texas, and Arkansas, distribute these reports to all PCCM providers. Other states provide the reports only to providers with a certain minimum number of beneficiaries assigned to them (e.g., North Carolina sends reports to providers with 50 or more

patients; Massachusetts, to those with 200 or more patients). To ensure that a significant amount of data is used in the analyses, most states only distribute the reports two to four times per year.

One complication in North Carolina is that some primary care providers submit claims using the Medicaid billing number for their group practice instead of an individual billing number. Since the name of the individual provider cannot be determined from the claim form, utilization and spending information from these claims cannot be incorporated into the individual provider profiles. ACCESS providers who use their own billing number and a group number may find that their quarterly provider profiles do not include all of the services they provided or referred for their assigned beneficiaries.

States also vary in what other groups primary care providers are compared to. For example, states produce reports that summarize the primary care provider's performance in a number of areas and provide comparative statistics on other PCCM providers in the same geographical region, other PCCM providers of the same specialty (e.g., pediatricians, internists), and/or all PCCM primary care providers.

These reports serve multiple purposes. First, they help providers see where their practice patterns differ from their peers, so that they can re-evaluate their performance. For example, a provider profile might show that a certain pediatrician provides far fewer immunizations than other local pediatricians. The doctor might decide based on this information to be more pro-active in identifying patients who are not up-to-date on their shots. A profile might also indicate that a higher proportion of the provider's patients use the emergency room than the patients of most comparable providers. This information might indicate to the doctor that he or she should spend more time educating patients on appropriate usage of the emergency room.

Exhibit IV-6. Innovative Reports Distributed by PCCM Programs

- Massachusetts sends reports to primary care providers twice a year listing all assigned beneficiaries who have not had a visit in the previous six months; providers can use these reports to contact beneficiaries who may need to come in for a check-up
- North Carolina sends monthly emergency room utilization reports to all PCCM providers, listing which of the provider's assigned beneficiaries used the emergency room in the previous month; this allows providers to conduct follow-up to determine if beneficiaries who needed emergency care need any ongoing care

Provider profiling reports also help state Medicaid staff identify providers whose practice patterns are substantially different from their peers, so that the providers can be educated about ways to improve their performance so that it is more consistent with standard practice. This could be done to encourage better use of generic medications, for example. The reports can also be used to determine the extent to which primary care providers are complying with the rules of the PCCM program. For example, a report that shows that a high proportion of a provider's patients use the emergency room might indicate to the Medicaid program that the doctor might not have adequate after-hours coverage or appointment availability, so patients are using the emergency room. Provider profiling reports all the state to monitor provider performance and target suggestions and action plans in an efficient manner.

c) Financial arrangements

Three of the five states surveyed pay primary care providers a case management fee each month. The other two use different approaches. The provider the bills Medicaid for individual medical services provided to their assigned beneficiaries. Many states limit the case management fee to two to three dollars per month; North Carolina pays $3.00 per month for the first 250 beneficiaries assigned to a provider, and $2.50 per month for any additional beneficiaries. Some states pay different fees for adults and children, or for disabled beneficiaries and families and children.

Oklahoma pays PCCM providers a higher monthly amount to cover more than case management. This partial capitation payment, which varies based on the age, sex, and eligibility category of each assigned beneficiary, is intended to cover the cost of providing case management, primary care services, basic diagnostic (lab and x-ray) services, well-child screens and immunizations, basic family planning services, and urgent care. Any other services delivered by the primary care provider or by another provider, such as hospital care or prescription drugs, would be paid by the state.

Instead of a fixed monthly per-beneficiary fee, Massachusetts pays an "enhanced case management fee" of $10.00 for certain types of visits, such as routine obstetric care, new and established patient visits, patient home visits, and preventive medicine services. This enhanced fee is provided on top of the regular amount paid for these services. The primary care provider receives the enhanced fee only for those patients assigned to the provider who receive the specified types of care, but if a given patient comes in more than one time per month, the provider will receive the extra fee for each qualifying visit.

d) Where North Carolina is at the forefront of innovations in PCCM

North Carolina has taken the next step of building on its basic PCCM experience to create programs that provide more than basic case management. ACCESS II and III were initiated in July 1998 and use groups of providers instead of individual primary care providers to coordinate a broader range of services for assigned beneficiaries. ACCESS II includes local networks comprised of Medicaid providers who have agreed to work together to develop the care management systems and supports that are needed to manage enrollee care. This model also includes a statewide network of large Carolina ACCESS practices who have agreed to work together to develop collaborative systems for managing care. ACCESS III, active in Pitt and Cabarrus counties, includes county-wide community partnerships involving physicians, hospitals, health departments, departments of social services, and other community providers. These networks will eventually assume responsibility for managing the care of the county's entire Medicaid eligible population.

The ACCESS II and III sites are required to develop and implement comprehensive care coordination strategies, including:

- A risk assessment process: utilizing an "at-risk" screening tool that identifies both medical and social risk factors;

- Reviewing emergency department utilization: integrating appropriate outreach, follow-up, and educational activities based on emergency department use by patients;
- Implementing disease management processes: using proven strategies to manage pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes;
- Implementing a care management process: identifying and targeting care management activities based on the screening process and other methods of identifying those patients at risk; and
- Identifying high cost and high users: developing and implementing activities that impact utilization and cost.

The ACCESS II and III sites are paid an *additional* $2.50 per member per month care management fee to pay for the infrastructure and staffing needed to provide these additional risk assessment, case management, and disease management services. This integrated approach to primary care case management in unique to North Carolina and will enable local providers to become much more involved in promoting the health of their communities. By working with larger groups of providers and assigned beneficiaries, DMA can develop and measure budget and utilization targets and quality indicators. This information can be used to further refine the delivery of services to Medicaid beneficiaries across the state. Finally, the extra funding given to demonstration sites and the new infrastructures that the sites will develop to provide the enhanced services will have spill-over effects that will strengthen the community safety-net that serves an expanding indigent population.

Recommendations

- ✓ Apply lessons learned from the ACCESS II and III demonstrations to the ACCESS I program and the traditional Medicaid program
- ✓ Export successful ACCESS II and III practices to other North Carolina counties
- ✓ Actively monitor ACCESS primary care providers to ensure delivery of program benefits

ACCESS II and II represent reforms that most states in the country are closely monitoring to learn from North Carolina. To make these programs pay off, DMA knows that it needs to manage the behavior of participating primary care providers to improve the beneficiaries' health care. In short, to ensure that ACCESS II and II are more than merely fee increases to primary care providers (in the form of supplemental monthly case management payments above ACCESS I), DMA must actively manage the primary care providers, which it told us it intends to do. Data should be coming in soon.

B. Private Insurers Use a Variety of Approaches to Develop and Manage Health Benefits

During March 2001, The Lewin Group conducted interviews with senior staff members from three of North Carolina's private health plans, as well as with the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter referred to as "State Employees' Plan"). We also reviewed public information from two additional North Carolina insurers. The goal of the interviews was not only to learn about the plans' benefit designs, but

also to examine the plans' processes for policy and implementation. Ultimately, these findings may prove useful in informing the State's process for Medicaid implementation.

In an effort to capture information on a large percentage of the State's private health plan enrollees, carriers were asked to provide information on their most popular products. These included products representing the range of private insurance options:

- Preferred provider organizations (PPO): members are encouraged to see providers on a select list through preferential cost-sharing and copays for "in-network" providers;
- Health maintenance organizations (HMO): members have a primary care provider or "gatekeeper" who provides referrals for specialty and hospital care; members are restricted to a network of select providers;
- Point-of-service plans (POS): a form of HMOs that allows members the option of seeing a non-network provider under some circumstances, with a higher amount of coinsurance; and
- Indemnity: traditional insurance in which members can visit any provider who accepts that type of insurance; indemnity insureds generally pay higher amounts of coinsurance than HMO and PPO members do.

We supplemented information provided by the carriers via fax and telephone interviews with data available on the plans' web sites. Plan name, product information and enrollment figures for each profiled product are provided in Exhibit IV-7.

Exhibit IV-7. North Carolina Insurers Surveyed

Plan	Product Name	Structure	Enrollment
BlueCross BlueShield North Carolina	Select Copay*	PPO	284,000
BlueCross BlueShield North Carolina	Blue Advantage**	PPO	110,000
United Healthcare	Choice Plus****	PPO	365,277
CIGNA***	Advantage 200	Gatekeeper HMO	400,000
CIGNA***	Open Access POS 1	Open Access POS Plan	60,000
State of North Carolina	State Employees' Plan	Indemnity/Major Medical	500,000

* Select Copay is a group product.

** Blue Advantage is an individual product very similar to Select Copay, but with higher patient cost-sharing.

*** CIGNA covers approximately 460,000 lives in North Carolina. Approximately 400,000 of these covered lives are in gatekeeper HMO products, of which Advantage 200 is probably the most popular product and is generally representative of all of Cigna's gatekeeper HMO products. The remaining 60,000 lives are in open access HMO Point-of-Service (POS) plans.

**** United Healthcare covers 365,277 lives in North Carolina. The Choice Plus product is the carrier's most popular product and is generally representative of United's product portfolio.

In addition to the interviews and analyses described above, The Lewin Group also examined the web sites of other major carriers in North Carolina, specifically Mid Atlantic Medical Services, Inc. (MAMSI) and Partners Health Plan. These reviews primarily focused on pharmacy benefit information.

1. Determining the scope and amount of services covered

North Carolina laws mandating coverage of certain services play a large role in determining the general benefit package offered by each insurer. While insurers are certainly free to go beyond the baseline set forth in the State's laws, competition and cost pressures prohibit insurers from offering much richer benefits than those offered by other insurers. For this reason, differences among basic benefit packages are minimal.

While the exact process for developing benefit policies varies among plans, all three of the plans that were interviewed were able to articulate their process for policy design and implementation. Plans described formal mechanisms used for policy development, as well as more informal steps that have been adopted to ensure that the appropriate policies are put in place. Each of the plans indicated that the process is team-oriented and designed to solicit input from internal personnel as well as from external stakeholders.

At Blue Cross Blue Shield, the product management department is responsible for making policy recommendations related to product designs. New designs and/or proposed changes to current products originate in the product management department and are then reviewed by a multi-functional group of people at the operational level. Blue Cross Blue Shield also seeks input from four external sources: providers on the BCBSNC panel, the North Carolina Medical Society, a community advisory council comprising group administrators, and the community via focus groups. Once the feedback from these groups has been incorporated, the proposed changes are submitted to the executive committee for approval.

United Healthcare's process for new product offerings is similar. Changes to United Healthcare's current offerings are frequently proposed by the health care cost team. The health care cost team is an internal team focused on medical expense monitoring and control. The plan's decision to increase emergency room copays from $50 to $100 originated with the health care cost team's analysis of emergency room utilization.

Committee structures, similar to United's health care cost team, are common among private health plans. The team composition of committees allows for input from a range of stakeholders, thereby making committees effective oversight mechanisms. Pharmacy and Therapeutics (P&T) committees are generally responsible for plan oversight of the pharmacy benefit, including the formulary. Utilization management committees are charged with reviewing trends and developing policies to ensure appropriate utilization. Committees similar to United's health care cost team are frequently responsible for controlling medical expenses.

United's health care cost team is also a good example of the way in which North Carolina's private plans incorporate feedback into the decision-making process. Monitoring, feedback, and evaluation were identified by the plans as critical components of policy development. Regular analyses of member claims assist plans in tracking utilization trends. Once a deviation from the normal trend has been identified, the plans undertake further analysis to determine if there is a correlation with quality of care or with expense. The person or team responsible for the analysis may create a recommendation for policy change. One of the plan's product managers stated that the recommendation usually results in one of three actions: a change in utilization management

policy, a restructuring of benefit packages, or a change in the plan's approach to provider education.

Each of the plans stated that once a policy has been implemented, the evaluation process begins immediately. The effect of the new policy is analyzed using data that is tracked in monthly, quarterly, and annual intervals. The private health plans may also undertake more comprehensive programmatic evaluations when major policy changes have been implemented. The University of North Carolina recently contracted with the State Employees' Plan to conduct an assessment of each of the plan's new disease management programs. The findings will inform the plan's future policies for disease management.

In general, private health plans in North Carolina are moving away from the more restrictive policies associated with managed care. Many HMOs have left the state entirely, and PPO and other open-access benefit designs are often the top-selling products. Gatekeeper HMOs (including those with lock-in and those with POS designs) are becoming less popular. As a result, many carriers have removed many of the established managed care restrictions from their products, particularly those associated with traditional HMO design. For instance:

- United Healthcare made a corporate decision that all products offered throughout the United States are open-access. That is, even within HMO lock-in and POS products, members do not need to go through their primary care physician to obtain access to a specialist.

- BlueCross BlueShield of North Carolina's (BCBSNC's) recently updated product portfolio also removed the gatekeeper function from all products. Both carriers found that virtually all referrals were approved, thereby rendering the function useless. Ultimately, the administrative burden was too expensive for a process that had minimal benefits for either the members or the plans.

- Even CIGNA, which has retained its gatekeeper HMO products, and in fact has most of its North Carolina members enrolled in such products, piloted its first open-access products in North Carolina. While the large majority of CIGNA's North Carolina members are enrolled in the gatekeeper HMO products, most *new* sales are in open-access models.

- After a detailed review process, which showed that United's medical directors deemed 98.5 percent of requests submitted by providers to be "medically necessary," United Healthcare of North Carolina decided in 1999 to delegate the large majority of medical necessity decisions to the treating provider.

- Health plan prior authorization of certain services—particularly physician office visit services and sometimes inpatient hospital admissions as well—is declining as a requirement.

In many ways, North Carolina insurers are adopting strategies currently used by the North Carolina Medicaid program (e.g., delegating many medical necessity decisions to providers, reliance on less restrictive forms of managed care). However, many of the formal process restrictions, such as prior approval and gatekeeper requirements, are being replaced in the private sector by higher cost-sharing and copayments, greater limits on the number of visits allowed, and more financial incentives for providers. Since some these tools are not available to the Medicaid

program, the trends in private insurance coverage towards less restrictive models may not be appropriate for Medicaid.

2. General utilization management strategies

The retreat from the most restrictive policies, however, belies the pains health plans are taking to control costs. Concurrent with the trend away from benefit management as "micro-management," the private insurance sector has begun to emphasize and/or adopt a number of other, less administratively burdensome, utilization management techniques. For instance, patient cost-sharing is increasingly being used as a strategy to indirectly control utilization. The private health plans also have begun to focus their utilization management efforts more narrowly than they had in the past. Programs geared to the entire membership are being replaced to some degree by strategies that concentrate on high-need, high-cost subpopulations.

a) Cost-sharing

All of the private plans report that an increase in cost sharing for members has been implemented within the past year. BCBSNC, United and CIGNA have all increased emergency room copays from approximately $50 to about $100. Management is hopeful that the higher copays will provide a disincentive for inappropriate emergency room utilization, as data indicated that member education was unsuccessful in doing so. The State Employees' Plan also is discussing the possibility of raising its emergency room copay, as it, too, has found a $50 copay to be too small a deterrent to inappropriate emergency room usage. Emergency room copays are perhaps the most common example, but plans have increased cost sharing on provider office visits, prescription drugs, and often other services as well. CIGNA indicated that it might also institute a separate copay for certain overutilized services, specifically citing MRIs as a likely candidate for such a copay.

Other services to which patient cost-sharing often applies include the following:

- Short-term occupational therapy and physical therapy
- Durable medical equipment (DME) and prosthetic devices
- Ambulatory surgery services (e.g., $50 copay per surgery)
- Behavioral health services (including inpatient and outpatient)
- Inpatient hospital confinements (e.g., $75 copay per admission)

As noted earlier, the ability of Medicaid programs to impose copays for Medicaid-covered services is restricted, limiting the usefulness of these kinds of financial incentives as a way to change beneficiary behavior.

b) Prior authorization

Prior authorization remains a requirement for services covered by many health plans. By all accounts, however, the list of services requiring prior authorization has narrowed over the past couple of years. United rarely requires prior authorization, and instead has altered its policy to require "notification" instead of authorization. A number of other plans indicated that, as

physicians have become used to managed care and are beginning to make only necessary referrals, there is less plan oversight of physician referrals. CIGNA indicated that it also has done away with many of the prior authorization requirements on hospital admissions, as well.

Instead, plans have begun to concentrate prior authorization requirements on high-cost services that are often inappropriately utilized. A number of plans, including BCBSNC and the State Employees' Plan, still require pre-certification of hospital admissions, and most require pre-certification of skilled nursing facility services and private duty nursing and behavioral health services. DME and prosthetic devices, home care, and hospice care are other services for which prior authorization is commonly required. In some cases, prior authorization must be sought only after a certain dollar, visit or day threshold is reached, e.g., the State Employees' Plan requires prior approval of durable medical equipment rentals and purchases over $250, and SNF care after the first 30 days.

Best practices in this area include the following:

- *Application of prior approval requirements to specific services that have been demonstrated to be outliers in terms of utilization.* For instance, one plan found that the use of MRIs and CT scans among its physicians in North Carolina was several times the nationwide norm, and the plan therefore instituted prior approval requirements for these procedures.

- *Differential application of prior approval requirements to different physicians based on their practice patterns.* Clinical profiling is used to determine which physicians exhibit appropriate patterns of utilization and which are "abusing" certain services. Prior approval requirements can then selectively be "turned off" or "turned on," accordingly.

- *Greater use of specialized companies to manage and authorize particular services.* For example, CIGNA has delegated prior authorization responsibility for MRIs and CT scans to MedSolutions; and for DME and home care to another third party.

These are all practices that could be adopted by the North Carolina Medicaid program, and might represent more cost-effective ways to direct scarce administrative resources for prior authorization to their best use.

Recommendations	
✓	Analyze which services are high-cost and high-use outliers and target the prior authorization strategy accordingly
✓	Perform active provider profiling to target authorization requirements for outlier providers

c) Medical necessity review

Although United has moved away from traditional medical necessity reviews, most plans continue to play an active role in medical necessity determinations and have service-specific medical policies that are used to determine whether the services are medically necessary. BCBSNC has taken steps to ensure that its medical necessity policies are based on national standards for best clinical practice and are updated frequently. Its medical policies are available on the carrier's web site. These policies not only detail coverage and exclusion criteria, but also

identify reference sources on which the policies are based and provide policy implementation and update information. The following excerpt from the "Sentinel Node Biopsy" policy (see Exhibit IV-8) outlines the background sources and comprehensive process used for this particular service.

Exhibit IV-8. Summary of Resources and Steps in Developing a Specific Clinical Policy

Scientific Background and Reference Sources

McMasters KM, Giuliano AE, Ross MI, et al. Sentinel Lymph Node Biopsy for Breast Cancer - Not Yet the Standard of Care. *New England Journal of Medicine* 1998;339(14); 990-995

Nieweg OE, Jansen L, Kroon BB, Technique of lymphatic mapping and sentinel node biopsy for melanoma. *Eur J Surg Oncol* 1998;24(6):520-4

Gennari R, Stoldt HS, Bartolomei M, Zurrida S, et al. Sentinel node localisation: A new prospective in the treatment of nodal melanoma metastases. *Int J Oncol* 1999;15(1):25-32

Pendas S, Dauway E, Cox CE, et al. Sentinel node biopsy and cytokeratin staining for the accurate staging of 478 breast cancer patients. *Am Surg* 1999;65(6):500-5;discussion 505-6

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McMasters KM, Tuttle TM, Carlson DJ, et al. Sentinel lymph node biopsy for breast cancer: a suitable alternative to routine axillary dissection in multi-institutional practice when optimal technique is used. *J Clin Oncol* 2000 Jul;18(13);2560-6

Policy Implementation/Update Information

8/99	Plan Consultant
9/99	Policy developed
12/99	Approved, Medical Policy Advisory Group
1/00	Policy implemented. Corrected last review date to appropriate date of 1/2000
2/01	Added new source to Scientific Background and Reference Sources. System coding changes

Other plans also indicated that they rely on national standards, as opposed to local practice patterns, in establishing medical policies. Many of the plans interviewed are national carriers that serve many national employers. It is therefore important that they promote consistency across their health plans to the greatest extent possible.

While Medicaid has the freedom to develop medical necessity criteria based on local or national standards, using more broadly-accepted criteria would likely be acceptable to North Carolina's providers, who are used to dealing with private insurers' and Medicare's rules. The use of national standards could also help ensure that North Carolina Medicaid benefits are being provided according to the state-of-the-art rather than local practice patterns that might lag behind. Finally, national accrediting bodies support this approach.

Recommendation

✓ Use medical necessity definitions that are based on national practice standards, not community practice standards

d) Clinical profiling

As prospective review has dwindled somewhat, there appears to have been a concomitant increase in retrospective clinical profiling of providers among the plans surveyed. Generally, physician profiling information is shared with providers in a positive and educational manner rather than in a punitive fashion. Plans have found that providing feedback to physicians relative to how they compare to their peers is often a powerful tool in changing behaviors and promoting best practices. Health plans appear to focus much of their clinical profiling around HEDIS measures such as for diabetic screening, mammograms, Pap smears, and so on.[5] CIGNA did indicate that such information, in addition to promoting best practices, is also useful to the plan in determining the providers with whom to renegotiate contracts.

Some provider profiling information is already used in the North Carolina Medicaid program: primary care providers who participate in the Carolina Access PCCM program receive periodic reports comparing their practice patterns to their peers. These profiles are used primarily for educational purposes, similarly to those used by private insurers. First Health, a contractor to the Medicaid program, performs provider profiling for drug prescribing patterns and provides education to outliers.

e) Disease management and case management programs

As mentioned previously, private plans have begun to abandon some of their plan-wide, non-targeted programs in favor of programs tailored to specific subsets of their membership. For instance, BCBSNC has discontinued administering health risk assessments to all new members in their HMO and POS products, largely because the return rate was very small and it was often the healthier members who completed the survey. At the same time, BCBSNC has expanded its disease management programs, rolling them out to its PPO products. In fact, each of the plans surveyed is emphasizing disease management as among their primary strategies for enhancing quality and controlling costs. The most common disease management programs are targeted at asthma, diabetes, and cardiovascular disease. Others named include lower back pain, osteoporosis, healthy baby, and smoking cessation. At least one plan offers special benefits to members who enroll in the disease management programs.

Many private sector plans believe that the traditional managed care approaches—discounted provider fees, indiscriminate prior authorization requirements, etc.—have run their course as effective cost containment strategies. They are increasingly developing the following types of programs aimed at truly managing care more effectively:

- United works with hospitals to develop short-stay protocols. Patients are observed for a period of time instead of being admitted to the hospital. This program has resulted in significant cost savings for United as well as for the patients (approximately 50-70 hematology/oncology admissions are avoided each month as a result).

[5] HEDIS, also known as the Healthcare Employer Data and Information Set, is a list of measures used by insurers and purchasers to monitor plan performance in a range of health care delivery areas. Health plans collect claims information on an annual basis to measure the number of women who receive a mammogram, the number of children who receive all necessary immunizations, etc.

- The company is also in the process of developing rapid rule-out myocardial infarction (heart attack) protocols for use by rural hospitals.

- United also utilizes a computer modeling program (IMPACT) that looks at historical utilization and predicts which patients will be high-cost in the future. The model identifies specific patients (e.g., diabetics who have stopped using insulin, hypertensives who are not complying with their medication regimens, individuals on multiple medications, etc.), thereby allowing United to intervene by increasing preventive care and educational strategies.

- CIGNA similarly identifies, through claims review, specific patients who might benefit from specific education. For instance, members who consistently are prescribed brand name drugs instead of generics might receive a mailing advising them of the lower copay associated with generic drugs and educating them about the generic substitute's efficacy.

In recent years North Carolina has begun implementing disease management and case management capabilities through the ACCESS II and III primary care case management programs, which pay qualified groups of providers an additional monthly fee per member to provide targeted case management, and focus on specific disease management initiatives such as asthma and diabetes. The clinical areas and case management techniques employed by North Carolina's largest private insurers suggest additional strategies that Medicaid could adopt.

3. Policies relating to specific services

In addition to examining North Carolina private health plans' processes for policy design and implementation, The Lewin Group profiled the pharmacy, reconstructive surgery, and behavioral health benefits of each of the plans. These services were chosen not only for their tendency to be high cost services, but also because they are representative of services that are difficult for state Medicaid programs to manage.

a) Pharmacy

As in the public health care sector, pharmacy costs in the private sector have been escalating rapidly, and the pharmacy benefit has thus become a major focus for cost containment efforts. Our discussions with private insurers in North Carolina therefore highlighted their prescription drug programs, including benefit structure, prior approval requirements, quantity limits, DUR, and special utilization management features. In addition to information obtained through our interviews with private insurers, we compiled available prescription drug benefit information from various insurers' web sites, including those of some insurers who were not interviewed.

(1) Benefit structure

A key objective of prescription drug benefit design in the private sector is to encourage the use of clinically effective generic drugs and cost-effective brand name drugs over the more expensive brand name drugs. This objective has generally been accomplished via the use of

closed formularies and/or differential cost-sharing obligations for the enrollee depending upon a drug's generic versus brand status.

Three-tier plans with differential cost-sharing obligations are most common among the private insurance products examined and appear to be gaining in popularity. For instance, Blue Advantage (the Blue Cross and Blue Shield of North Carolina's popular individual product) has recently moved from a two-tier to a three-tier prescription drug plan, and United Health Care switched from a closed formulary to a three-tier plan within the last year. The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan ("State Employees' Plan") converted its 80/20 drug benefit to a three-tier plan recently, as well. The typical three-tier plan consists of an open formulary structured as depicted in Exhibit IV-9.

Exhibit IV-9. Typical Tiered Formulary Structure

	Tier 1	*Tier 2*	*Tier 3*
Types of Drugs Included	All generic drugs	*Preferred Brand or Formulary Brand* Brand name drugs that are clinically effective, cost effective, and meet the needs of most patients	*Non-Preferred or Non-Formulary Brand* Generally includes brand name drugs that do not have a generic equivalent, but have a therapeutic alternative available in Tier 2; brand name drugs that have a generic equivalent; and often brand name drugs not usually used as the first line of treatment.
Copay	Lowest copay, typically $10	Middle copay, typically $15 or $20	Highest copay, typically $20 to $40

At least two plans (State Employees' Plan and BCBSNC) have adopted or are considering adopting additional tiering mechanisms. Acting upon changes made to the State Employees' Plan during the 2000 Session of the General Assembly, the Plan entered into a contract in December 2000 with Advance PCS, upon which time a four-tier plan, structured as follows, was implemented:

- Tier 1 – generic drugs - $10 copay
- Tier 2 – single source brand with no generic equivalent - $15 copay
- Tier 3 – preferred brand name drug with a generic equivalent - $20 copay
- Tier 4 – non-preferred drugs - $25 copay

Of the plans we investigated, only CIGNA and Partners Health Plan have closed formulary benefit structures, with no coverage for off-formulary drugs. (In some instances, the prescribing physician may request an exception if he or she feels that a non-formulary drug should be prescribed.) In addition, some brand name drugs on Partners' formulary are covered only up to the cost of the generic form of the drug, i.e., the enrollee must pay the difference in cost between the brand name and the generic in addition to the copay.

North Carolina Medicaid may not be able to implement an effective tiered copay structure due to limitations on the amount of copays that can be charged to beneficiaries (federal law limits Medicaid copays to $3 per prescription) and the fact that many Medicaid beneficiaries (e.g., children, persons in nursing homes) are excluded from copay requirements by federal law.

(2) Prior approval requirements

Prior approval requirements vary widely across the private health plans examined. The North Carolina State Employees' Plan, again in compliance with changes made to the Comprehensive Major Medical Plan during the 2000 Session of the General Assembly, now requires prior approvals for drugs for erectile dysfunction, growth hormone, anti-wrinkle, weight loss, and hair growth. BCBSNC's drug prior approval requirements apply only to its HMO products, and only to Botulinum-A (Botox) and Growth Hormone injectable drugs. CIGNA indicated that the number of drugs on its prior approval list is also small, "probably numbering as few as three." The number of drugs included on the prior approval lists of the other plans researched ranges from 5 (United Health Care) to approximately 45 (Partners) specified drugs. MAMSI's prior approval listing includes specific drug and dosage forms, as well as all compound drugs over $100. Lists of drugs requiring prior approval in each of these health plans are included in Appendix J.

Generally, insurers characterize drugs requiring prior approval as those that may be used inappropriately and/or may be used for medical issues not covered by the health plan (e.g., hair loss, wrinkles, weight loss). Typically, physicians wishing to prescribe a drug on the prior approval list must call the health plan (or the health plan's pharmacy benefit manager) prior to prescribing and provide member clinical information in order to obtain approval.

As discussed in more detail in Chapter 2, North Carolina Medicaid requires prior approval for only a small number of drugs. The list of drugs requiring prior approval included as Appendix J may suggest additional drugs or drug categories that Medicaid might add to its list.

(3) Quantity limits

With the exception of the State Employees' Plan, the health plans examined also set quantity limitations on a number of medications for which there is a significant potential for abuse or misuse, which may be dangerous in large quantities, and/or to encourage the use of FDA-approved drug regimens. BCBSNC's list of drugs with quantity limits, which the interviewee indicated applies to all products, includes eleven drugs. CIGNA also designates quantity limitations for a small number of drugs. Other plans researched have designated upwards of 75 drugs, including those named by BCBSNC, as subject to quantity level limitations. BCBSNC's on-line medical policy pertaining to "Quantity Limitations for Prescription Drugs" details the process and required documentation required for the prescribing physician to exceed the limit specified (see Exhibit IV-10).

Recommendation
✓ Adopt drug dosing limitations based on drugs most likely to be abused

Currently, North Carolina has a single quantity limit of 100 days for all covered prescription drugs. There is considerable room for refining these limits as private

insurers have done. These limits are similar to those used by other state Medicaid programs as well. The process Blue Cross uses to evaluate requests to exceed the day and quantity limits could be a useful model for North Carolina Medicaid to adopt to ensure that those beneficiaries who have a medical need that requires an exception are able to obtain one.

Exhibit IV-10. BCBSNC Billing/Coding/Physician Documentation Requirements

Required documentation for exceptions to the quantity limits is as follows:

All requests for benefits exceeding quantity limit guidelines must include pertinent records and/or information required to conduct utilization management review for quantity limits. Pertinent records and/or information may include, but is not limited to the following:

- Medical records indicating the failure of typical drug doses in treating the member's condition;
- Specified rationale for treating the member condition with greater than typical drug dosages;
- Pertinent medical records documenting member's history.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Providers who persistently prescribe quantities exceeding the quantity limit guideline or present atypical practice patterns will be identified and reviewed for potential quality of care issues.

(4) Drug utilization review

BCBSNC, MAMSI, and United Health Care all use Merck-Medco as their pharmacy benefits manager (PBM), while Partners contracts with Express Scripts, the State Employees' Plan with Advance PCS, and CIGNA with a CIGNA-owned company by the name of Rx Prime. These PBMs perform traditional drug utilization review (DUR), both prospective and retrospective, on behalf of their clients, including reviews focusing on drug-to-drug interactions, duplicate therapy, improper dosing, drug-allergy interactions, drug-age complications and fraud or abuse.

North Carolina Medicaid currently performs limited prospective and retrospective utilization reviews for prescription drugs. Prospective review is not a utilization management tool, but is instead intended to detect the same sorts of problems private insurers use it for: drug-to-drug interactions, duplicate therapy, etc. Retrospective DUR is used to identify improper usage or problem prescribing patterns and educate providers and to a lesser extent, beneficiaries.

(5) Pharmacy fees

The insurers were unwilling to share specific fee information with The Lewin Group project team. However, chronicling the dispensing fees paid by the State Employees' Plan sheds some light on the typical fee paid within the private sector. Prior to August 1, 2000, the State Employees' Plan's dispensing fee had been $6.00 per prescription. Changes to the Plan implemented as a result of the 2000 Session of the General Assembly included a decrease in the dispensing fee to $4.00, effective for the period August 1, 2000 through June 30, 2001. As of July 1, 2001, the fees are slated to come in line with "market conditions," which State Employees' Plan staff indicated will mean a reduction to between $1.50 and $2.00 per

prescription. This range was confirmed by another health plan to be in line with what private plans are paying.

(6) Special drug utilization management features

A number of other utilization management features mentioned by the companies interviewed are worth noting, as they represent practices that may not be universal across all health plans and may suggest best practices in this area. They are as follows:

- BCBSNC's products do not allow a long-term supply to be filled on the first prescription of a drug. For initial scripts, there is a 30-day supply maximum, so that the patient and physician can determine whether the drug prescribed works for the patient. Only after the initial 30-day supply may the patient obtain an extended supply.

- BCBSNC's point-of-sale utilization review program ensures that a prescription refill is honored only after two-thirds of the time period covered by the prior supply has elapsed.

- Retrospective profiling of physician prescribing patterns appears to be increasing at a number of health plans. United Health Care, for instance, stepped up such profiling when it converted its prescription drug benefit structure from a closed formulary to a three-tiered system. Such profiling not only seeks to ferret out atypical prescribing practices that may be more costly, but also to highlight and share with physicians information on how they compare with their peers in complying with nationally accepted best practices in specific areas. For instance, United has shared information with its physicians on their prescribing of beta-blocker drugs for survivors of heart attacks.

- MAMSI's and United's 2000 formularies include specific information on the use of medications in the elderly.

- United's formulary (available on-line as are many health plan formularies) includes, for a number of medications, guidelines for the medication's use. An example is provided in Exhibit IV-11.

Recommendation

✓ Eliminate blanket 100 day pharmacy supply, and replace with shorter or tiered approaches (e.g., no more than 30 days for first fill, and no more than 60 days for refills)

These practices should be considered for adoption in some form by the North Carolina Medicaid program, as they may enable the State to continue to achieve its access goals while better managing pharmacy costs. For example, if the State chooses to maintain its 100-day limit for most or all Medicaid-covered drugs, it might want to consider using a strategy such as BCBSNC's, in which new prescriptions are limited to a 30-day supply. For many drugs, 30 days would allow sufficient time to determine if the medication is working for a patient, and might prevent 60 to 75 days' worth of a drug being thrown out because the remained of a 100-day supply is not used.

Exhibit IV-11. Sample Pharmacy Guidelines From United Health Plan

Hypertension

- A diuretic and/or a beta-blocker are recommended asinitial therapy for uncomplicated hypertension unless the patient has a comorbid condition or a compelling indication.
- Angiotensin II receptor blockers should only be used in patients who cannot tolerate an ACE inhibitor.
- Most patients should be reexamined within 1 to 2 months after beginning drug therapy to access therapeutic effect, patient compliance, and tolerance.
- After hypertension has been controlled effectively for at least one year, it is possible to decrease the dosage and the number of antihypertensive drugs. The reduction should be made in a deliberate, slow, and progressive manner.

References:

The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med*. 1997;157:2413-2446. Found at the following Internet address: http://www.nhlbi.nih.gov/guidelines/hypertension/jnc6.pdf

b) Reconstructive surgery

While all of the health plans interviewed cover only "medically necessary" reconstructive surgery (i.e., surgery for cosmetic reasons is not covered), they differ with respect to the amount of documentation they require in order to confirm medical necessity. The State Employees' Plan indicated that the area with the greatest potential for abuse is rhinoplasty, and surgeons are required to submit a considerable amount of documentation, including surgical notes, so that the Plan may determine coverage. United, on the other hand—in keeping with the lower level of "micro-management" the Plan has adopted—requires very little documentation, asking the physician simply to note that the surgery was necessary to correct "functional impairment." Interestingly, though, United's representative indicated that physicians continue to send in much more documentation than is requested (e.g., clinical notes for the past six to 12 months) because they are accustomed to doing so for some other health plans.

BCBSNC requires a considerable amount of documentation, as well, and in the absence of documentation the procedure is considered cosmetic and not covered. General documentation required by BCBSNC for determining whether a procedure is cosmetic or reconstructive is outlined in the on-line medical policy, excerpted in Exhibit IV-12. In addition, for each specific procedure that may be cosmetic or reconstructive, there is a medical policy that details more specifically the medical necessity criteria and documentation required (see Appendix K for an example).

Recommendation

✓ Widely distribute the criteria to be applied to approve surgeries, not just the program manual. Consider using an Internet-based distribution vehicle.

While North Carolina Medicaid's utilization review contractors use medical necessity criteria and review documentation to determine the appropriateness of many elective surgeries, the detailed standards used by the contractors are not always available to providers. The provider manuals and bulletins distributed to Medicaid providers describe the information that must be submitted for review but not the criteria that will be used to evaluate the information. Without this information, it can be difficult for providers to assess

beforehand whether a case meets the criteria, or to determine specifically why a rejected request was not approved.

DMA should consider using a mechanism such as the Internet to provide these more detailed medical criteria to providers. This would help providers avoid making requests that will not meet the State's criteria and help providers better explain to members why given procedures are not covered. Greater physician access to utilization review criteria may also help strengthen the criteria themselves: physician will be better able to judge if the decisions made by the utilization review contractor are consistent with the criteria to ensure that decisions are being made fairly. Physicians will also be able to comment on the content of the standards, which may lead to improvements in how they are defined and applied.

Exhibit IV-12. Documentation required by BCBSNC for prior authorization review

Billing/Coding/Physician Documentation Information for Reconstructive Surgery

Refer to the individual codes for each specific procedure.

If documentation is requested, it should include the following:

- Medical records indicating that the procedure will be or was performed to restore/improve bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic process. In the absence of this documentation, the surgery or procedure must be considered cosmetic.
- Photographs
- Copies of consultations
- Operative reports
- Any other pertinent information

c) Behavioral health

Among the health plans surveyed, management of behavioral health services utilization is generally accomplished through patient cost sharing, dollar limits, visit and day limits, and/or prior authorization.

All of the private plans have policies for cost sharing for members. BCBSNC's Blue Advantage product requires a 50 percent coinsurance that is subject to a calendar year deductible. BCBSNC's Select Copay product, United, State Employees' Plan and CIGNA have all set member copays ranging from $10 to $30 for outpatient visits.

BCBSNC and CIGNA are currently the only plans that place dollar limits on behavioral health services. BCBSNC's Blue Advantage allows $2,000 maximum per person per calendar year with a lifetime maximum of $10,000. Both CIGNA and BCBSNC's Select Copay limit substance abuse services to $8,000 maximum per person per calendar year and are capped off at a $16,000 lifetime maximum.

While United does not place dollar limits on BH/SA services, it does limit outpatient and inpatient behavioral health services to 20 visits and 30 days per calendar year respectively. BCBSNC's Select Copy and CIGNA also place limits on outpatient visits and inpatient stays

ranging from 20 to 30. It must be noted, in this context, that mental health "parity" is not required in North Carolina.

Prior authorization guidelines between the four health plans vary from not requiring any PA (Blue Advantage and CIGNA Advantage 2000) to requiring PA for all non-emergency behavioral health services (United). State Employees' Plan stipulates that the first 26 visits per fiscal year do not require prior approval. However, in order to obtain precertification for 27 or more visits the provider must submit an updated outpatient treatment report at the 18th visit.

Exhibit IV-13 summarizes whether and how each health plan employs each of these techniques.

Exhibit IV-13. Private insurers' use of behavioral health utilization management techniques

	Patient Cost-Sharing	Dollar Limits	Visit/Day Limits	Prior Authorization
BCBSNC Blue Advantage* (Behavioral Health Vendor: Magellan)	50% Coinsurance, subject to calendar year deductible	$2,000 max per calendar year per person $10,000 lifetime max	NA	NA
BCBSNC Select Copay* (Behavioral Health Vendor: Magellan)	$10 member copay per visit	No max on BH On SA: $8,000 max per calendar year per person $16,000 lifetime max	*Outpatient:* 30 visits per calendar year *Inpatient:* 30 days per calendar year	None on outpatient;** Precert required on inpatient
United (Behavioral Health Vendor: United Behavioral Health)	$15 copay for group visits; $30 copay for individual visits 20% coinsurance for inpatient behavioral health	NA	*Outpatient behavioral health:* 20 visits per calendar year *Inpatient behavioral health:* 30 days per calendar year	All non-emergency behavioral health services must be approved in advance by United Behavioral Health
State Employees' Plan (Behavioral Health Vendor: Value Options)	*Outpatient:**** $10 copay per visit; also subject to Plan deductible and coinsurance *Inpatient:* Subject to Plan deductible and coinsurance, plus a $75 special deductible per admission	NA	NA	First 26 visits per fiscal year *do not* require approval;***** All other behavioral health and chemical dependency services must be approved in advance by Value Options

	Patient Cost-Sharing	Dollar Limits	Visit/Day Limits	Prior Authorization
CIGNA Advantage 2000 (Behavioral Health Vendor: CIGNA Behavioral Health)	*Outpatient:* $20 copay per visit *Inpatient:* 20% copay *Day Treatment. Facility* 15% copay	No max on BH On SA: $8,000 max per year $16,000 lifetime max	*Outpatient BH:* 20 visits per year	
CIGNA Open Access POS 1*	*Outpatient:* $30 copay in-network *Inpatient:* $50 copay per day in network *Day Treatment Facility* $40 copay per day in network	No in-network max on behavioral health; On SA: $8,000 max per year, $16,000 lifetime max	*Outpatient BH:* 25 visits per year *Inpatient BH:* 25 days per lifetime *Outpatient SA:* 25 visits per year *Inpatient SA:* 25 days per lifetime	Member must obtain prior authorization from CIGNA Behavioral Health in order for BH services to be paid as in-network benefits

* In-network benefits are shown on chart; greater patient cost-sharing generally applies to out-of-network benefit. Some services are not covered out-of-network.

** BCBSNC HMO products do require precertification for outpatient as well as inpatient.

*** Only one type of outpatient behavioral health or chemical dependency service may be paid per day.

**** To obtain precertification for 27 or more visits, the provider must submit an updated outpatient treatment report at the 18th visit.

The extent to which North Carolina Medicaid can implement similar controls on behavioral health utilization is limited by federal restrictions on Medicaid policy. For example, the maximum copay that a Medicaid program can implement is $3 (North Carolina currently has a $3 copay for outpatient behavioral health visits for adults). Similarly, Medicaid cannot impose annual or lifetime dollar limits on services. However, North Carolina can—and does—use day and visit limit and prior authorization controls to manage behavioral health utilization.

C. Best Practices and Lessons Learned for North Carolina

States and insurers use a variety of techniques to develop and manage specific benefits and contain the scope of the benefits package as a whole. Some of the best practices used by the states and insurers interviewed for this study that North Carolina should consider adopting are summarized below.

Recommendations	
Strengthen the policy development and review process	
✓	**Designate internal resources to systematically review coverage policies**, trend data, and new services. Some states and insurers use multiple teams and committees to review benefit policies (e.g., Pharmacy and Therapeutics Committee, Utilization Review Committee, Cost Containment Committee). Creating dedicated groups helps ensure that policies are periodically and consistently evaluated.
✓	**Use expert and community sources of input** to identify and evaluate new benefits or changes. Expert input can include in-house resources, external expert advisors, medical societies and boards, and medical literature. Community input can be provided by network providers, beneficiaries, and advocates. Using both types of input will help ensure that benefit policies represent the state-of-the-art in medicine and can be implemented effectively in the community.
✓	**Make ongoing evaluation of new policies and changes a priority** by starting the assessment process as soon as a new policy is implemented. Private insurers in particular closely monitor the delivery of new benefits to determine the impact on cost, utilization, and access. Performing monthly, quarterly, or semi-annual reviews of data can identify trends on a timely basis and suggest mid-course corrections if the new policy or change is having unintended consequences.
Use a broad range of techniques to manage utilization and control costs	
✓	**Target limits and prior authorization requirements** to a small group of benefits chosen on the basis of utilization, cost, approval or denial history, and fraud and abuse history. This will minimize the resources needed to enforce benefit limits while maximizing the results of those efforts.
✓	**Delegate utilization review to independent contractors** who specialize in certain benefits. An independent contractor that focuses on utilization review of a particular benefit (e.g., pharmacy, behavioral health) can provide broad and deep expertise and adjust quickly to industry changes. An independent contractor may also be less vulnerable to political pressure to change the interpretation of certain standards.
✓	**Provide reasonable exceptions to arbitrary limits** (e.g., day or visit limits) to ensure that beneficiaries who have a medical need for additional services are able to access them, and that the exceptions are reviewed and evaluated consistently rather than on an ad-hoc basis.
Provide clear and timely guidance to providers	
✓	**Develop approaches to accelerate the utilization review process** to reduce barriers to care and other unintended consequences. Ensuring that prior authorization requests are processed in a timely manner supports a provider's ability to manage a patient's care and reduces the amount to which patients and providers may attempt to circumvent system controls.
✓	**Ensure that providers are aware of the plan's standards and criteria** to help them better plan their patients' care. Making detailed utilization criteria available to providers will help decrease the number of requests that will be denied and help ensure that criteria are consistently applied.

✓	**Conduct periodic provider profiling efforts** to educate doctors about their performance and their peers and help them improve their practice patterns. States and private insurers have found that providing physicians with information on how they compare to their peers and to medical standards is a very effective mechanism for encouraging providers to self-improve.

V. FINDINGS AND RECOMMENDATIONS

Many of the earlier recommendations can be accomplished without legislative action. In this chapter, we will outline a short list of recommendations that require legislative consideration.

A. Impact of Proposed Changes on North Carolina Medicaid Beneficiaries

The introduction to this paper outlined the fundamental tension facing state Medicaid programs: how to ensure access to sufficient health benefits while containing costs and maintaining program integrity. We have identified several ways in which DMA has tipped the balance in favor of access, making it harder to contain costs, in the absence of the strategies linked to Exhibit I-4 in the Introduction. The recommendations noted throughout this paper and in these concluding chapters are aimed not to restrict access and tightly control costs and utilization. We are instead suggesting that DMA can introduce some utilization management and program integrity controls that will reduce the errors that lead to overutilization, while still ensuring that Medicaid beneficiaries have access to medically needed services, along the lines of Exhibit I-4.

We believe that our recommendations will not adversely affect beneficiaries, for the following reasons:

- Lowering provider fees should not significantly decrease provider participation in Medicaid;
- Strengthening utilization management controls should not limit access to medically necessary care; and
- Improving program management should have positive consequences across the health care system.

1. Lowering provider fees will not significantly change Medicaid participation

Provider reimbursement in the North Carolina Medicaid program is very high compared to all of the state's neighbors and to the rest of the US—North Carolina ranks seventh in the country in Medicaid payments to physicians.[1] Medicaid payments were not always so high—they were increased from 91 percent of Medicare allowable fees to 100 percent just over one year ago to entice more providers to participate in the Medicaid program, thereby intending to increase access for beneficiaries. Given the high physician participation rates prior to the increase, such a substantial increase may not have been necessary. In fact, the former 91 percent of Medicare fees rate was also high compared to most states, and even then was six full percentage points above any neighboring state.

Given that North Carolina physician fees appear to be greater than necessary to sustain adequate access for Medicaid beneficiaries, it is reasonable to assume that were the rates lowered somewhat, beneficiary access would not be significantly impaired. As discussed in Chapter II, DMA would not need to lower rates across the board: an evaluation of provider rates across a range of specialties might reveal that some provider types (e.g., pediatricians) have high rates of participation in Medicaid, while others (e.g., dentists) have much lower participation. DMA

[1] Comparison of Physician and Dental Fees Paid by State Medicaid Programs, Medi-Cal Policy Institute, 2001.

recommended, at an approximate cost of $642,000 per year. The recommended positions include:

- **Two hearings officers.** The additional hearing officers will help process nursing home level of care appeals. Nursing homes currently have two levels of care: skilled and intermediate. Reimbursement for skilled care is substantially higher than reimbursement for intermediate care. If an external review finds that a patient currently receiving skilled care only requires intermediate care, the patient can appeal and remain in skilled care until DMA hears the appeal and decides which level of care is appropriate. If the hearings officer finds that the intermediate level of care should have been provided during the appeals period, the state will have unnecessarily paid for the higher level of care during that period. The appeals process is currently backlogged approximately six weeks, meaning that DMA may be paying for a higher level of care than necessary for some patients for up to six weeks. Reducing the backlog and amount of time needed to schedule new hearings will increase savings to the state by reducing unnecessary payments for higher levels of care. The addition of two hearings officers should enable DMA to reduce the backlog and hear new appeals in a timely manner.

- **Five medical review nurses, four investigators, and one clerical support person.** The Program Integrity Unit reviews Medicaid claims, medical records, and other data to determine if providers have billed services in error, either intentionally (e.g., fraud or abuse) or unintentionally (e.g., claim submitted twice in error, service mis-coded on a bill). In the past three years Program Integrity has made substantial investments in new technologies, including a data warehouse, computer network, and new fraud and abuse detection software. These technologies have enabled Program Integrity to speed up the detection of potential cases of fraud, abuse, or error, which potentially means that monies can be recovered and returned to the state more quickly. However, additional staff are needed to conduct the manual reviews and investigations needed to pursue cases identified by the new software system. The addition of these ten staff people will enable Program Integrity to more effectively use the information generated by its existing computer resources.

- **Two home care nurse reviewers.** As noted in Chapter III, many community/home care services are authorized according to a patient-specific plan of care. The service limitations in the plan of care cannot currently be enforced by the EDS claims processing system. The addition of two home care nurse reviewers would allow DMA to DMA estimates that the addition of two home care nurse reviewers could improve oversight of medical necessity and allow for enforcement of any additional limitations identified to be cost beneficial.

2. Other resources

Many of the services discussed in this report have addressed the need for additional utilization management activities. It is up to the state to decide whether or not these suggested tasks can be best performed by an outside contractor or by in-house staff, but either way additional resources need to be spent on management tools and staffing to support these activities.

DMA is advised to review their former approach of contracting with, and/or hiring, medical experts for input into benefit coverage decisions. These individuals are necessary for help in

determining medical necessity criteria, for staying updated on new procedures and technologies, and for help in assessing requests for coverage exceptions. These experts, whether hired as staff or as outside consultants to the division, will serve as a central resource for the DMA Medical Director and for the various persons making daily prior authorization decisions. Their advice will help DMA move from the "community standards" definition of medical necessity to definitions based on evidence-based medicine.

DMA also should evaluate whether to consolidate or limit the number of outside contractors involved with performing overlapping prior authorization tasks. It is difficult to manage the services being provided when there are so many entities involved playing roles within the same service.

C. Potential Cost Savings

The Introduction of this report laid out a fundamental tension in all state Medicaid programs: how to balance the desire to advance access to care for program beneficiaries against the desire of taxpayers to contain program costs. Striking this balance is not an exact science. The potential cost savings identified in this chapter should be understood in that context.

The approaches outlined below represent the best places to start because they represent areas where North Carolina is more generous in its approach than other states, and/or they represent approaches utilized within North Carolina by other health insurers (and therefore should be familiar to North Carolina providers who also deal with these other insurers).

1. Pharmacy authorization process to encourage use of less expensive drugs

State Medicaid programs we surveyed during the course of this review have implemented more advanced and aggressive prior authorization processes than North Carolina has adopted. We estimate that adoption of prior authorization procedures for a handful of medications offers the prospect of over $50 million per year in program savings.[2]

Needless to say, to achieve these savings the state must have a sufficient administrative infrastructure to review and process physician requests for prior approval of these drugs, as well as the functionality in the Medicaid fiscal agent system to enforce the prior authorization guidelines.

In our interviews with the state Medicaid program's Pharmacy Director we heard him say that it is his opinion that the administrative cost of installing and maintaining a prior authorization program will exceed the savings in program expenditures, making it a cost ineffective strategy. We were unable to obtain from him the data he used to substantiate this opinion.

Other state Medicaid programs and other insurers believe quite the opposite. Georgia's Medicaid program published data that its prior authorization program saves $16 for every $1 it costs. Using

[2] All savings figures are stated in total dollar terms. To derive the savings in terms of state and local funds the Medicaid FMAP must be used.

this rough figure in North Carolina would result in the expenditure of $3.44 million in administrative costs to save $55 million in drug expenditures, or a net gain of over $50 million ($16.3 million in state funds). Moreover, the state could elect alternative administrative strategies to build up a drug prior approval program, from contracting this out to a pharmacy benefit manager (PBM) to growing a deeper staff at DMA.

2. Reduce physician fees to a lower percentage of Medicare

North Carolina presently pays its physicians the seventh best fees of the 51 state Medicaid programs (including the 50 states and the District of Columbia) Appendix B. The states that pay more than North Carolina are all in the far west, with the exception of Vermont which landed in fifth place. North Carolina's fees are far higher than any of its neighboring states and any of the other states in the southern and eastern portions of the United States.

On a weighted basis, North Carolina pays 100.1 percent of Medicare allowable charges, or equivalent to Medicare. Near North Carolina, the next highest states are Tennessee (85.0 percent of Medicare), Kentucky (84.5 percent), Georgia (82.6 percent), and Virginia (81.7 percent). South Carolina (66.2 percent) is far below any of those states.

If North Carolina reduced its Medicaid fees back to 91 percent of Medicare, it would save $50.9 million in total funds ($16.5 million in state funds) without negatively affecting access. If North Carolina instead reduced its fees to 85 percent of Medicare allowable charges, in order to equal the next highest paying neighboring state, it would save $84.75 million a year in total dollars ($27.6 million in state funds). The effect on access at 85 percent of Medicare is unknown.

3. Eliminate chiropractic and podiatrist services

Only about half of the states include podiatrist and chiropractic services for adults in their Medicaid state plans. (The majority of states include these services for children due to their interpretation of their obligations under EPSDT).

Dropping these two services for adults will not save a large percentage of the Medicaid budget's overall expenditures – they are relatively small ticket items. Still, eliminating these services could save approximately $2.4 million (see table below). We do not recommend this elimination without a careful analysis of the benefit it provides (as discussed in the report), but we did want to note it as the legislature faces a budget problem.

	Expenditures Individuals < 21	Expenditures Individuals 21+	Total Expenditures
Chiropractic	$293,629	$791,110	$1,084,739
Podiatry	$208,835	$1,606,613	$1,815,448
Total	$502,464	$2,397,723	$2,900,187

Source: DMA statistics, SFY00

VI. CONCLUSION

In conclusion, the state Medicaid agency generally does a good job in designing and managing the Medicaid benefit package. Its motivation consistently is to serve the program's beneficiaries, often by building solid relationships with the providers who deliver the care.

Medicaid goes astray, in our opinion, in a few ways. First, it sometimes errs in taking providers' desires so much into account that it fails to adequately contain costs. The absence of a rigorous pharmacy benefit management program and the generous physician fees are two examples.

Second, the Medicaid program acts based on political pressures. This is difficult for any Medicaid program to avoid, but it contributes to problems such as the preferential treatment accorded to Area Mental Health Authorities (over private behavioral health providers), and to the omission in the design process of more scientific research into data and medical literature.

Overall we were impressed with the commitment and professionalism of the Medicaid agency staff, and believe it will take seriously constructive reforms to its process. We greatly appreciate their cooperation in this project.