GOVERNOR'S FORUM ON MEDICAID
NHHA STATEMENT ON SUGGESTIONS FOR IMPROVING MEDICAID

January 24, 2005

Good morning, Governor Lynch. Thank you for the opportunity to participate in this important dialog today on the future of Medicaid in New Hampshire

My name is Leslie Melby, and I am the Vice President of State Government Relations of the New Hampshire Hospital Association on behalf of the state's 32 acute care community and specialty hospitals.

This past summer, (the New Hampshire Hospital Association) we submitted 52 recommendations to DHHS listing our ideas for improving the state's Medicaid Program. Some of our recommendations included:

- requiring pre-authorization for high cost, non-emergent diagnostic services;

- implementing rigorous case management for high cost cases such as heart failure, asthma, diabetes, low birth weight babies and the like;

- expanding the network of physician providers to promote better management of care, more rational utilization of emergency room services, prevention, and early intervention.

- Providing reasonable reimbursement for services, so that providers don't opt out of the Medicaid program. The availability of more providers will reduce unnecessary use of more expensive services, such as those provided in hospital emergency rooms.

- Improving Medicaid performance by establishing databases for monitoring performance and comparing Medicaid performance to that of other payers.

- Helping to contain costs by covering hospice care and palliative care. Each year about 700 Medicaid patients die, 100 of which are under 65 years of age. Hospital claims account for 40% of the costs attributable to their care. NH is one of only a few states that do not cover hospice care. Adding it would be both humane and cost effective.

In addition, a number of our recommendations address Medicaid's administrative systems that require providers to jump through hoops to get paid. On the day-to-day business side of the Program, we've suggested a number of ways to modernize claims processing, which should save the state in administrative costs and, in turn, save providers the added expense they currently incur just to get paid. We realize that the state will be installing a new MMIS system, but we hope not to wait two years for some of these simple measures to be implemented.

The Medicaid Program in New Hampshire has had its successes. Success can be measured in the number of children receiving primary care they might not otherwise have received; in the number of people who are disabled or elderly who receive ongoing medical and social supports that allow them to remain in their own homes and even allows some disabled folks to work and earn a living; and the number of developmentally disabled individuals who, just a little more than two decades ago, would have been institutionalized.

But along with the successes, the Medicaid program has been cumbersome and inefficient. Why, for example, do Medicaid recipients rely on safety net providers such as hospital emergency rooms to meet their basic healthcare needs? To begin with, access to physician practices is limited either because the practices are full or … because Medicaid reimbursement is just too low, and practices cannot subsidize the state.

So, as a last resort, people turn to the hospital emergency room. As you know, hospital emergency departments are not only very expensive places to go to for primary care, they are inappropriate places to go for primary care. But if you can't get into a doctor's office, what else can you do? Well, you either delay receiving some form of care until your condition worsens and then get the care you need in the more expensive hospital setting – at an even higher cost if you're admitted as an inpatient; or you just go ahead and use the hospital for your basic healthcare needs.

And then there's the vast majority of unnecessary emergency room visits paid for by Medicaid that are attributable simply children's earaches and sore throats – and that's surprisingly mostly on weekdays – not weekends – obviously care that should have provided in a primary care setting.

Consider, for example, a very young, perhaps a teen mother who, in desperation, takes her infant to the hospital emergency room screaming in pain from, say, an ear infection.

Where else can she go? She doesn't have a pediatrician, a family physician or a nurse practitioner. Or she does, but they tell her to wait until later in the day to be seen. The baby keeps crying and she can't take it any longer. So she runs to her local hospital where she's certain her infant will be seen sooner or later in the emergency room.

One way to change this behavior is to educate Medicaid enrollees about how to properly use the health care system. Such a program succeeded in California in which parents of children on Medicaid were given a reference book and guidance on how to use it. For those who participated, visits to the **hospital emergency room dropped by 48% and visits to the doctor dropped 38%.** This program estimates that training 12,000 families would cut Medicaid costs by at least $2.4 million annually.

However, this type of program won't succeed if we don't have sufficient numbers of primary care providers willing to see Medicaid patients. According to DHHS, there's a disproportionate burden on the few primary care physicians and nurse practitioners who accept Medicaid patients. A small percentage of physicians provide the majority of care for Medicaid enrollees – that's about 14% of physicians who account for about 75% of Medicaid claims. In primary care, about 19% of primary care providers account for about 75% of Medicaid primary care. The combined effect of inadequate payment rates, underparticipation and disproportionate demand prompts more physicians to drop out of the Program. This is a death spiral. If the goal is to improve cost-effectiveness, then expanding the network of participating physicians is imperative.

With more PCPs available, patients would be less likely to use hospital emergency departments for primary care – a very expensive proposition for Medicaid. Incentives such as improved reimbursement should be implemented, and would be offset by reduced use of expensive emergency room care.

We believe all of our recommendations warrant a second look. We've commented on those aspects of the Medicaid program we know best, but all program components of Medicaid intersect. The point at which nursing home residents enter the acute care system should not be viewed as a hand-off, but rather as a manifestation of an interconnected system in which all parties must partner – including the State, which has both the well-being of patients as well as the cost of their care to consider.

Harnessing long term care costs is essential, and is a much larger piece of the Medicaid system in terms of cost. However, Medicaid recipients who are elderly and disabled navigate the entire healthcare system – not just the long term care system. A more holistic approach - a systems approach – to healthcare in general, with care management as its cornerstone – should work. If we don't move ahead in this manner – partnering with all players in the system and investing prudently in the development of community-based options– we're likely to see a long term care system where patients default to the most expensive healthcare setting.

Thank you.