We are pleased to present the State Fiscal Year 2008-2009 report on the Pennsylvania Medical Assistance Program. We continue to strive to assure access to quality health care for all Pennsylvanians who are eligible for Medical Assistance. Pennsylvania remains in the forefront of Medicaid programs nationally in implementing innovative programs and initiatives to enhance quality of care, improve access to care and efficiently manage costs. We hope that this report provides you with valuable insight into our commitment to invest in and protect the long-term health and welfare of Pennsylvania’s most vulnerable citizens.

Fiscal Year 2008-2009 was another tight budget year for the Commonwealth as a whole. The slowing economy has caused revenues to fall well below projections. Further complicating the picture is the steady increase in those enrolling for Medical Assistance; a growing elderly, children and disabled population; the rising cost of health care; and the loss of federal funding. While many program offices saw significant budget cuts, the Medical Assistance program was fortunate to be able to continue to provide coverage for the growing number of individuals and families who need our assistance.

Despite these difficult economic times, Pennsylvania’s Medical Assistance Program continues to find new ways to deliver quality services more efficiently. Areas we focused on for this fiscal year included refining pharmacy services, improving our pay for performance program, enhancing our managed care program, improving care coordination, implementing new technology, and expanding fraud and abuse efforts.

A few highlights of our accomplishments this year include:
- Reducing our pharmacy expenditures while increasing federal rebate collections
- Expanding the Preferred Drug List to 75 drug classes
- Implementing a Specialty Pharmacy Drug program
- Implementing prior authorization for radiological imaging services
- Implementing predictive modeling to identify high risk ACCESS Plus recipients for case management
- Reviewing Preventable Serious Adverse Events in hospitals

Pennsylvania continues to build on its success from previous years which has allowed us to maintain our commitment to assuring that health care services delivered through our Medical Assistance program are held to a high standard of quality and excellence.

We anticipate FY 2009-2010 to be equally challenging economically; however, Pennsylvania will continue its efforts to respond to the health care needs of Pennsylvania’s citizens, provide access and quality of care, and improve health outcomes through innovative initiatives and program efficiencies. This report is a testament to the fine work of the staff of Pennsylvania’s Medical Assistance Program and our many business partners.
Overview

This report provides a summary of the Medical Assistance program in Pennsylvania. It looks back at the services, programs, initiatives and operations during State Fiscal Year 2008-2009 (FY 08-09) which ran from July 1, 2008 through June 30, 2009.

As detailed on page 4, over 1.9 million residents of Pennsylvania received services under the Medical Assistance Program in FY 08-09. And as summarized on page 5, most Medical Assistance consumers are eligible for a broad array of services. In total, over $14.8 billion was spent in providing medical services to consumers in FY 08-09. Close to 70 percent of these expenditures were for the elderly and disabled. See page 6 for more information.

On page 7 is an update on the HealthChoices Program which now serves over 1.2 million consumers in 26 counties. As the HealthChoices Program has matured, the consumers it serves are able to take advantage of expanded case and disease management programs which are resulting in notable improved health outcomes. Similarly, page 8 provides an update on the ACCESS Plus Program which operates in the 42 counties where HealthChoices is not available. As of June 2009, ACCESS Plus provided primary care case management for over 312,000 Medical Assistance consumers. Over 38,000 ACCESS Plus consumers were enrolled in disease management programs for asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) or congestive heart failure (CHF). The ACCESS Plus Program is proving to be a highly successful way to manage care in non-urban areas.

Pages 9 through 12 provide an update on our extensive efforts to promote and achieve excellence in quality. A major element of our quality management strategy focuses on the continuous assessment of the quality of care provided to our recipients. Pages 9 and 10 highlight these assessments. Page 11 provides current information on our childhood obesity, smoking cessation in pregnant women and domestic violence programs – all very high priorities. Lastly, our pay-for-performance (P4P) initiatives are detailed on pages 12 and 13.
Some of the significant changes we have made in our program operations are described on pages 14 and 15. One of the most notable is that in 07-08, we were awarded a Transformation Grant for Predictive Modeling, a process of identifying potential candidates for case management. Another major enhancement is that in January of 2008, the Department implemented a policy for Preventable Serious Adverse Events (PSAEs). This is defined as an event that must be preventable, occurring during a hospital admission, within control of the hospital, and is both adverse and serious in nature or results in significant harm.

Page 16 includes information on our pharmacy initiatives. Fiscal Year 08-09 revealed the culmination of several years of efforts to improve management of the pharmacy benefit program. Starting in 2004, the Office of Medical Assistance (OMAP) has made a concerted effort to bring pharmacy benefit management in line with commercial pharmacy programs. The most notable new Pharmacy initiative is the implementation of the Specialty Pharmacy Drug Program.

Our ability to streamline claims processing functions and to take advantage of Internet capabilities has been aided significantly by the PROMIS™ claims processing and management information system initially implemented in March 2004. Today PROMIS™ processes more than 100 million claims annually and provides state-of-the-art features as outlined on page 17. As part of our fiscal responsibility to the tax payers of Pennsylvania, we have renewed our efforts to attack fraud and abuse in the program. The Pennsylvania Fraud and Abuse Detection System (FADS) is used to profile providers and recipients to identify abnormalities or patterns of misuse for further investigation, as you will read on page 18.

One way in which we have tried to improve our program administration is to take full advantage of new technology. Pages 19 and 20 summarize the many Internet capabilities now available to medical providers to make it easier for them to participate in the program, to serve Medical Assistance consumers and to submit claims. Today, providers can access all Medical Assistance policies directly through the Department of Public Welfare’s Web page. They can also update their enrollment information electronically and submit claims directly from their office computers.

The final chapter in this report (pages 21-23) lists all of the committees and members who have helped us refine and improve the Medical Assistance program in Pennsylvania. We appreciate their dedication and commitment to our clients and business partners.
The Office of Medical Assistance Programs administers the joint state/federal Medical Assistance program that purchases health care for more than 1.9 million Pennsylvania residents. Major program areas include: managed care services purchased on a prepaid capitation basis, long-term care, inpatient hospital care, and outpatient services purchased on a fee-for-service basis. In addition, program responsibilities include monitoring fraud and abuse activities and assessing the quality of care received by recipients enrolled in both fee-for-service and managed care plans.

The Medical Assistance Advisory Committee (MAAC) and its subcommittee advise on issues of policy development, program administration, access to service and quality of service. The subcommittees include: Consumer, Long Term Care, Managed Care and Fee-for-Service.
Medical Assistance Eligibles

Medical Assistance (MA) recipients generally fall into five groups: children and families, the elderly, the disabled, adults, and chronically ill. Medical Assistance enrollment has increased steadily in the last nine years and in FY 08-09 the Medical Assistance Program covered services for over 1.9 million recipients. The elderly are the fastest growing group of Medical Assistance recipients.

The Medical Assistance program provided health care coverage to over 1.9 Million Pennsylvanians in FY 08-09
Medical Assistance Services

The federal government allows states flexibility in determining the amount, duration and scope of MA services. In order to receive federal matching funds, states must cover specified mandatory services. All optional services are mandatory for children under age 21 when they are medically necessary.

Mandatory Medicaid Services

All Medically Necessary Care for Eligibles Under Age 21 (see box below)

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physicians’ Services
- Nurse Practitioner Services
- Nurse-Midwife Services
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
- Laboratory and X-Ray Services
- Nursing Facility Services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services for Recipients Under 21 Years of Age
- Family Planning Services and Supplies
- Medical and Surgical Services of a Dentist
- Home Health Services

Pennsylvania Medicaid Optional Services

(Optional Services must be covered for recipients under age when Medically Necessary)

- Podiatrists’ Services
- Optometrists’ Services
- Chiropractors’ Services
- Medical Supplies and Equipment
- Ambulatory Surgical Center
- Independent Medical Clinic/Surgical Center
- Psychiatric Clinic
- Psychiatric Partial Hospitalization
- Drug & Alcohol Outpatient Clinic
- Birthing Center Services
- Renal Dialysis
- Dentists Services*, including orthodontics
- Physical Therapy, Speech Therapy, and Occupational Therapy Services**
- Prescribed Drugs*
- Prosthetic Devices*
- Rehabilitative Services
- Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) and Other Related Conditions (ICF/ORC)
- Primary Care Case Management (PCCM) Services
- Transportation Services
- Home and Community-Based Waiver Services
- MA Case Management (recipients under 21)
- Targeted Case Management
- Personal Care (recipients under 21)
- Hospice Care Services
- Inpatient Hospital and Nursing Facility Service for 65+ in an Institution for Mental Disease (IMD)

What is Medically Necessary?

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability and is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate for members of the same age.

* Medically Needy Adults are not eligible for these services, with some exceptions.
** For Adults, these services are provided by a Hospital, Outpatient Clinic or Home Health Provider.
Medical Assistance Budget

Pennsylvania’s Medicaid budget, including both state and federal funding, grew by approximately 1 percent in FY 08-09 over FY 07-08.

Medical Assistance Expenditures

Families represent the vast majority of MA recipients at 66 percent, but they only account for 33 percent of the spending. The elderly make up only 14 percent of the recipients, but account for 33 percent of the spending. Together the elderly and disabled contribute to 67 percent of the MA expenditures.
Capitated Managed Care

HealthChoices is the name of Pennsylvania’s mandatory managed care program. Through physical health managed care organizations (PH-MCOs) recipients receive medically necessary care and timely access to all appropriate physical health and pharmaceutical services covered under the MA program. Through behavioral health managed care organizations, recipients receive medically necessary mental health and drug and alcohol abuse services. (The behavioral health component of HealthChoices is overseen by the Department of Public Welfare’s Office of Mental Health and Substance Abuse Services.)

Over one million recipients are enrolled in HealthChoices in twenty-five counties that comprise three geographic zones.

Pennsylvania’s Voluntary Managed Care Program operates in 26 counties. More than 71,000 MA recipients are enrolled in one of the MCOs that provide voluntary physical health services.

The HealthChoices MCOs provide perinatal care management services for pregnant women and also provide several Disease Management Programs for chronic conditions including asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure. The PH-MCOs also provide health management services to meet the needs of consumers with targeted conditions such as hemophilia, sickle cell disease, and HIV/AIDS.
ACCESS Plus is Pennsylvania’s Enhanced Primary Care Case Management (EPCCM) and Disease Management Program for MA recipients who reside in the 42 counties of Pennsylvania where HealthChoices is not operational. ACCESS Plus has been fully operational since May 2005. Voluntary Managed Care also operates in 26 of these 42 counties. Consumers in these 26 counties may choose to participate in either ACCESS Plus or the Voluntary Managed Care Program.

The ACCESS Plus program enables MA recipients to choose their own Primary Care Providers (PCPs), and receive active care coordination, case management and, if eligible, Disease Management services.

PCPs serve as primary care case managers for ACCESS Plus enrollees. They serve two functions by both providing and managing recipient care. Services include issuing specialty referrals, locating specialists, and maintaining continuity of care.

Care Coordination services are available to all ACCESS Plus enrollees to focus on and improve health care outcomes and eliminate barriers to accessing necessary services. These administrative services help enrollees by locating specialists, scheduling appointments, providing reminder calls for appointments, arranging transportation to medical appointments, and coordinating services with other agencies including behavioral health and children and youth.

Case Management services are available to enrollees with more complex care needs. In order to maintain or improve enrollees’ health status, there is an ongoing assessment of needs, patient education and referrals to various services within the program.

Disease Management services are provided to enrollees with the following conditions: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), and Congestive Heart Failure (CHF). Disease Management is a system of coordinated health care interventions and communication for recipients with conditions in which patient self-care efforts are significant. As of July 2008 there were 38,645 enrollees in ACCESS Plus Disease Management.

ACCESS Plus achieved $8.5 million in medical services cost savings for the Disease Management population as measured by the ACCESS Plus Guaranteed Savings Calculation.

The ACCESS Plus Diabetes Collaborative employed the model developed by the Institute for Healthcare Improvement. The model is an improvement method that relies on the spread and adaptation of existing knowledge to multiple settings to accomplish a common goal. This Collaborative focused on: monitoring the progress of the disease, assessing enrollee self-management and lifestyle changes, and promoting the importance of preventive care.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Enrollment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>312,070</td>
<td>68%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td></td>
<td>3%</td>
</tr>
</tbody>
</table>
The mission of the Office of Medical Assistance Programs (OMAP) is to “Promote excellence through quality, access and service in the Medical Assistance Healthcare system.” A major element of our quality management strategy is to focus on the continuous assessment of the quality of care provided to our recipients. One of the tools to measure that quality is through the performance measures.

The HealthChoices Managed Care Organizations (MCOs) continue to perform well in the clinical Health Care Effectiveness Data Information Set (HEDIS®) quality measures. The 2008 US News and World Reports Best Health Plans ranked UPMC for YOU 13th out of 80 Medicaid plans in the nation and Gateway Health Plan ranked 19th. Both outstanding HealthChoices plans are included in the top 20 Medicaid plans across the country. Additionally, the five remaining plans are ranked in the top 50% nationally. The rankings were determined from data obtained through the National Committee for Quality Assurance HEDIS® quality metrics. To further promote quality and accountability, we annually publish “A Consumer’s Guide to the HealthChoices Health Plans.” This brochure ranks the HealthChoices MCOs’ rates for select performance measures related to quality of care received, access to care and special needs. The Consumer Guides are also available for each of the three HealthChoices zones. The three zone level consumer guides are specific to the area where a member resides. To support the Consumer Guide, the Department issues the HealthChoices Performance Trending Report. This report summarizes data collected from the HealthChoices MCOs for the period from January 1, 2008 through December 1, 2008.

The Department continues its commitment to improve the quality of care for consumers by identifying barriers to care such as health disparities through the collection of race and ethnicity data for fourteen HEDIS® measures. The Department shares this data with the HealthChoices MCOs to assist the plans in identifying health disparities and focus their outreach efforts. National initiatives are moving toward identification of race and ethnicity disparities and the development of targeted interventions, making Pennsylvania a leader in this area.

Emergency Department (ED) utilization for Medicaid recipients continues to increase and remains an area of concern not only nationally but particularly for Pennsylvania. To address these issues, the Department is initiating an ED Performance Improvement Project (PIP) for all HealthChoices MCOs. Attention will be given to the percentage of “low acuity” ED visits by MCO, region, race and ethnicity, as well as additional MCO and county level detail. Submissions began in November 2009 and evaluations of the projects continue into 2012.

In addition, the Department and UPMC for You received an Emergency Department Diversion Grant from the Centers for Medicare and Medicaid Services. The objectives of this grant are to reduce non-emergent patient visits to the ED at UPMC McKeesport and establish or strengthen individuals’ connection to a medical home in the community. The UPMC Project Director has been connecting area behavioral health, children and youth, community organizations and healthcare facilities. A Patient Navigator at UPMC McKeesport has been educating and connecting patients to PCPs since April 2009, and additional mid-level clinical practitioners will be utilized at the participating primary care practices.

For HealthChoices, a new monitoring tool was piloted in 2008, the Pay-for-Performance (P4P) Matrix Report Cards. The MCO specific “Report Cards” provide a comparative look at 11 of the HEDIS® measures included in the HealthChoices MCO P4P Program.
The Matrix:

- Compares the MCO’s own P4P measure performance over the two most recent reporting years (HEDIS® 2007 and HEDIS® 2008); and

- Compares the MCO’s HEDIS® 2008 P4P measure rates to the HEDIS® 2008 HealthChoices Weighted Average.

An additional monitoring tool developed and implemented in the HealthChoices Program in 2008 is the Case and Disease Management report. The HealthChoices MCOs are required to submit quarterly data on Asthma, Cardiovascular/Congestive Heart Failure, Diabetes and Perinatal cases and disease management programs. The report evaluates the program description and scope of both in-house and vendor contracted programs, staffing ratios, severity level stratification, members enrolled in case and disease management, and member outreach and interventions conducted each quarter. In 2009 the MCOs will be required to report additional information quarterly on the number of members who are receiving active case management.

In the ACCESS Plus program, analysis was performed on many of the pertinent Medicaid related HEDIS®-like measures. Over the last four years many of the rates have remained stable or showed improvement. Improvements have been made in preventative health care for children, annual dental visits, lead screening, timely onset of prenatal care, and in Diabetic care measures.

One initiative currently being used to improve diabetic care is the ACCESS Plus Diabetes Collaborative which involves three practice sites from the northwest region of the state. Each site is monitoring ten clinical measures related to diabetes care. The collaborative focuses on monitoring the progress of the disease, assessing enrollee self-management and lifestyle changes and promoting the importance of preventative care. Bringing a poorly controlled diabetic under control saves money, improves the well-being of the consumer and saves money.

Another component used to evaluate quality and access to care is patient satisfaction. A comprehensive survey was completed for ACCESS Plus enrollees who participated in the ACCESS Plus Disease Management Program for at least six months. Results of the satisfaction survey demonstrated a high degree of satisfaction with all elements of the program, especially the program staff. Ninety-eight percent of the respondents reported they “probably would” or “definitely would” recommend the DM program to a friend or family member with a similar health condition.

ACCESS Plus also conducted a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This survey measures consumer satisfaction with a variety of components of the ACCESS Plus program. In the child survey, on a scale from 1-10, 82.3% of ACCESS Plus enrollees rated their health plan an 8, 9, or 10, compared to 77.9% in 2008. In the adult survey, on a scale from 1-10, 70.9% of ACCESS Plus enrollees rated their health plan an 8, 9 or 10 compared to 67.5% in 2008.

In 2008-2009, the Office of Medical Assistance participated in three national learning networks and workgroups. Two were with the Center for Healthcare Strategies (CHCS) and included:

- “Reducing Disparities at the Practice Site” which supports quality improvement in small practices serving a high volume of racially and ethnically diverse Medicaid beneficiaries. The three-year initiative is testing the leverage that Medicaid agencies, health plans, primary care case management programs and other community-
based organizations have to improve chronic care at small practices serving this population. The goal is to improve health among adult Medicaid patients with diabetes, as measured by statistically significant improvements in diabetes-related HEDIS® measures for engaged members.

The **Innovations Project** is being implemented on July 1, 2009 and will continue until June 30, 2011. Pennsylvania was among eight states selected by CHCS to participate in this multi-stakeholder initiative. It provides a unique opportunity for Pennsylvania to test new approaches to physical health/behavioral health integration as a way to achieve better outcomes for individuals, while at the same time spending less money.

The third project was with the Agency for Healthcare Research and Quality (AHRQ) Medical Directors Learning Network. This project provides opportunities for Medicaid medical directors to exchange information and strategize on areas related to clinical care in their population.

Childhood obesity is a burgeoning health care crisis and we continue to work at increasing consumer awareness of these services and make improvements in the delivery of these services. The MA program was nominated by the Department of Health (DOH) for substantial contributions to the state’s nutrition and physical activity efforts and received the Centers for Disease Control award “Partner in Advancing Public Health” for our childhood obesity initiatives.

Additional quality related program services include: Domestic Violence (DV) and Tobacco Cessation. The Department worked with the DOH to develop a tobacco cessation toolkit and distribute them to all FQHCs and RHCs statewide.

The DV workgroup continues to develop standardized articles for our MCOs and ACCESS Plus programs to publish in their newsletters. We participate on many statewide workgroups, such as the Asthma and Diabetic Partnerships’ workgroups, with the goal to educate consumers and reduce the burden of disease among these consumers.

Preventable Serious Adverse Events (PSAEs) are medical events that occur during an inpatient hospital visit, result in significant harm to the patient and are deemed to be preventable and within the control of the hospital. In the Department, one new innovation is tracking and evaluating Preventable Serious Adverse Events (PSAEs). This is an innovative state model that is part of a national focus on preventing medical errors. Stakeholders are exploring new ways to hold providers accountable for and eliminate preventable medical errors that result in serious harm to the patient. The next step is to look at expansion of the PSAE process to include long-term care.
Pay for Performance (P4P) is an innovative way to reimburse practitioners based on health care quality and outcomes. OMAP has implemented P4P programs within the managed care and ACCESS Plus delivery systems as well as in hospital based care.

**Plan P4P**
The HealthChoices P4P program originated in 2004 to encourage continuous quality improvement among the MCOs. Since then, the P4P program has made progress toward accomplishing the program goals of improved quality, access, and efficiency by aligning payments with high-quality health care for all members, engaging Pennsylvania in the national movement toward value-based purchasing, promoting preventative care, and improving access to primary care and providing a medical home for members. Measures were selected for the program based on:

- Historical program-wide need for improvement;
- Breadth of impact across the HealthChoices population; and
- Consideration of high-profile indicators for chronic disease with larger potential for impact on quality and savings.

HealthChoices performance has improved since implementation with increases in 10 of 13 weighted averages and no statistically significant declines from the baseline year. Improved plan performance ultimately benefits members’ quality of life, saves lives, and reduces inappropriate health care costs.

Performance based contracting in the HealthChoices Program is based on HEDIS® rates for twelve measures. HealthChoices had statistically significant improvement in 9 of 11 HEDIS® quality between 2008 and 2009. These measures fall into four broad categories: chronic care, preventive care and early detection, prenatal care, and utilization. Within the chronic care category are controlling high blood pressure, cholesterol management, type two diabetes monitoring, and asthma measures. The preventive care and early detection category includes four measures: breast and cervical cancer screening, adolescent well-care visits, and the childhood blood lead screening measure for children. Prenatal care covers rates for prenatal care in the first trimester and frequency of ongoing prenatal care. Emergency room utilization and ambulatory care are the utilization measures. The Department selected these measures because their improvement will have a positive impact on members’ lives.

The ACCESS Plus vendor, McKesson Health Solutions, is responsible for performance around five quality measures modeled after HEDIS®: prenatal care, ER visits per 1,000 members, well-child visits ages 3-6 years, adolescent well care visits, and cervical cancer screenings. McKesson exceeded the goal for adolescent well care visits. The ER visits per 1,000 members exceeded the goal of 40.6%.

Since 2005, the ER Visits per 1,000 members improved from 61.1% to 39.9% (for this measure, a lower number is better); the well-child visits 3-6 years of life improved 11.6%; the frequency of ongoing prenatal care visits remained stable; cervical cancer screening improved 7%; and the well child visits 12-21 years of life improved 14.5%.

**Provider P4P**
The Department recognizes that the MCO’s success in achieving and sustaining improvements in the quality of care provided to its members is closely related to the performance of its providers. The provider Pay for Performance (P4P) program was designed to provide additional funding to the MCOs to implement a new provider incentive program or enhance an existing provider P4P program for their provider network. Each MCO was strongly encouraged to align their provider P4P program with the goals included within the Commonwealth’s Prescription for Pennsylvania initiative as well as the quality measures included in the Department’s MCO P4P program. The Department added approximately $1.00 to each MCO’s Per Member Per Month (PMPM) Capitation payment to fund their provider P4P program. All of the additional funding must be paid in incentives to network providers. The Department implemented the provider P4P program July 1,
2007. From July 1, 2007 to December 31, 2007 the program was voluntary. Beginning January 1, 2008, the provider P4P program became mandatory for the MCOs to participate.

In the ACCESS Plus Physician P4P: During the past year the program focused on its continued effort to increase voluntary participation by the network’s primary care physicians. Physician participation increased from 1,581 to 2,088 during the year. In addition, the P4P program gives providers financial incentives for accepting new ACCESS Plus patients and for expanding office hours. The most significant improvements are related to diabetes, asthma and cardiovascular care.

The ACCESS Plus Dental P4P added metrics to incent dental providers to create a “dental home” for recipients, encourage dentists to see pregnant women, and when clinically indicated encourages them to render periodontal treatment for patients with diabetes and/or cardiovascular disease. Prevention and management of periodontal disease has been found to reduce the risk of premature births and to reduce the risk of further cardiovascular events. Incentives are also provided to dentists who do comprehensive and maintenance care rather than just episodic interventions.

**Hospital Quality**

The hospital quality care investment grant provides a $1 million grant program to provide up to $50,000 per facility in funds for quality-related projects. The hospital may define a project but the area of focus for the Department are the use of technology to promote pharmacy error reduction, a single medical record, the use of electronic emergency department records, projects which demonstrate a positive impact on the treatment of chronic disease, and a project that will have a positive impact on patient outcomes and quality of medical services.

Twenty-five of 26 hospitals eligible applied for funding and 22 were awarded grants. Of those 22 grants awarded, 15 focused on health information technology and 7 focused on improved care coordination.
In FY 08-09, nearly 13,417 new providers enrolled in the Medical Assistance Program. To enroll, providers must meet applicable national, federal and state licensing and certification requirements. The Department remains focused on recruiting providers to service our recipients.

The Division of Provider Services continues to assist providers and recipients through our established 800 lines. In FY 08-09, the **Provider Service Center** answered more than 185,000 incoming inquiries from providers. The **Recipient Service Center** answered more than 3,500 incoming calls from recipients and helped 274 individuals with Limited English Proficiency (LEP) needs by providing interpreter services.

**Prior authorization** is required for certain medical services or items, including inpatient, short procedure unit, ambulatory care center, rehabilitation, durable medical equipment, dental, and advanced radiologic imaging requests. In FY 08-09, Medical Review processed over 150,000 prior authorizations. Information regarding pharmacy prior authorizations can be found on page 16.

In January of 2008, the Department implemented a policy for **Preventable Serious Adverse Events** (PSAEs). A PSAE is defined as an event that must be preventable, occurring during a hospital admission, within control of the hospital, and is both adverse and serious in nature or results in significant harm. Other states have recognized PA MA for pioneering a unique approach to Preventable Serious Adverse events and are basing their own processes on our model.

In July 2004 the **Intense Medical Case Management** (IMCM) Program, which is staffed with general nurse case managers and high risk maternity nurse case managers, was created. These nurses manage recipients with complex or coexisting conditions including amputations, burns, cancer, surgical issues, coordination of care issues, medial supply issues, high-risk pregnancy, utilization of home health care, HIV, high-risk neonates, organ transplants, and traumatic brain injury, among others. In FY 08-09, close to 1,050 new referrals were received each month, and 2,060 cases were actively managed.

IMCM nurse care managers utilize predictive modeling software to identify potential candidates for case management. This process stratifies recipients based on risk scores. By identifying high-risk patients earlier in the process, or capturing those patients who were not previously managed, we can improve quality and better control cost.
**Rate Setting** within the Office of Medical Assistance Programs supports **Disproportionate Share Hospital (DSH)** and **Supplemental Payment**, including the following 22 payment programs to private inpatient hospitals for FY 08-09.

- Inpatient DSH
- Volume DSH
- Outpatient DSH
- Medical Education
- Hospital Quality Care Incentive Pilot
- Program for Inpatient DSH and Volume DSH
- Hospital Quality Care Incentive Pilot Program for Medical Education
- Community Access Fund (CAF)
- Academic Medical Centers
- Access To Care
- Additional Class of DSH 1
- Additional Class of DSH 2
- Augmented Waiver
- Burn DSH
- Critical Access Hospitals
- Hospital Quality Care Investment Grants
- OB/NICU
- Outpatient / Emergency Room
- Psychiatric Medical Education
- State Grants (related to CAF)
- Tobacco Uncompensated Care
- Tobacco Extraordinary Expense
- Trauma DSH

Payments for all of the above-referenced payment programs, except for the State Grants, were processed through PROMISe™. A total of 1,605 payment transactions occurred within PROMISe™ to support these payment programs. Of those transactions 1,414 were payments, while 191 were credit adjustments. For FY 08-09 there were a total of five State Grants which were processed directly through the state’s accounting system. Additional payment adjustments are anticipated for FY 08-09 Tobacco Extraordinary Expense Payment Program pending review by the Auditor General’s Office.

In addition, Trauma DSH payments for FY 08-09 have been indefinitely suspended due to a court injunction.

As of publication of this report, private inpatient hospitals received a net total of $529,606,463.78 (state and federal funding) for the 22 payment types referenced above for FY 08-09. Trauma DSH payments are anticipated to add nearly $25 Million.

During the Fiscal Year ended June 30, 2009, the Rate Setting reviewed and accepted 213 **Hospital Cost Reports** (MA-336). Cost Report data is critical and used for the computation of hospital base payment rates, many of the above-referenced DSH and supplemental payments, as well as federally mandated hospital upper payment limits.

In an effort to stabilize reimbursement rates for **Program Exception Items** throughout the commonwealth, Rate Setting assumed responsibility for pricing certain requests in February 2009. Rate Setting developed a database dedicated to housing program exception requests, cost information, and payment assignment for numerous items. The Department is better able to establish more consistent pricing throughout the Commonwealth and research data contained within the database for use in establishing rates. Between February and June 2009, 992 exception requests were recorded in the database and priced.
During FY 08-09, the Office of Medical Assistance Programs (OMAP) continued to achieve significant advancements in management and operations of pharmacy services in its Fee-for-Service delivery system. Improvements, many of which are consistent with industry standards, began in 2005, with annual enhancements to existing initiatives and the implementation of new initiatives. New initiatives to date include the introduction of a Preferred Drug List (PDL), appointment of a Pharmacy and Therapeutics (P&T) Committee, establishment of a Pharmacy Prior Authorization Call Center, collection of supplemental rebates, enrollment in a multi-state Medicaid state supplemental drug rebate pooling initiative approved by the Centers for Medicare and Medicaid Services (CMS), introduction of market share rebates for diabetic supplies, and publication of a list of drugs subject to quantity limits and dose optimization. Improvement to existing operations included a reorganization of the Drug Utilization Review (DUR) Board, enhancements to the DUR processes, expansion of clinical prior authorizations to address health and safety concerns, maximization of collections of federal rebates, increased utilization of generic drugs, and upgrades to the Department’s pharmacy services Web site.

The most notable new pharmacy initiative was the implementation of the Specialty Pharmacy Drug Program. The Medical Assistance (MA) Program was the first Medicaid program in the nation to selectively contract through the competitive bidding process with two specialty pharmacies to serve as the Department’s preferred providers of specialty drugs. This program provides a reliable, convenient, cost-effective dispensing and delivery system for expensive oral and injectable medications used to treat chronic and life-threatening diseases. The program facilitates care in clinically appropriate settings, and provides a clinical support system designed to optimize therapy management, care coordination, and patient compliance.

In FY 08-09, OMAP also expanded the PDL to include over 70 drug classes, the list of drugs subject to quantity limits, and the list of drugs subject to clinical prior authorization. OMAP implemented a requirement for prior authorization of early refills and introduced automated prior authorization of selected drugs in FY 08-09.

The cumulative result of all of these initiatives is a reduction in pharmacy expenditures from an average of $73.00 per member per month (PMPM) in state FY 05-06 to an average of $25.05 in FY 08-09 (accounting for all rebates). This is a reduction of 65 percent. Most important, OMAP achieved this reduction while increasing access and quality of care.
PROMISE<sup>TM</sup>, the Medical Assistance claims processing and management information system that was implemented in March 2004, offers numerous benefits to the provider community allowing them to focus more attention on patient care. Providers can use PROMISE<sup>TM</sup> to electronically file claims for all claim types and make claim adjustments. Another function available through PROMISE<sup>TM</sup> is recipient eligibility verification including information for specific procedures and drugs.

PROMISE<sup>TM</sup> also has been working to allow providers to send and receive information electronically. Over 97 percent of claims are received electronically. Additionally, providers have the option to receive claim payments electronically, receive Remittance Advices electronically, and received MA bulletins electronically.

A pilot project that allows providers to fax pharmacy prior authorization requests to the FFS Pharmacy Unit was implemented in July 2009.

In FY 08-09 PROMISE<sup>TM</sup>:

- Processed more than 113 million claims and encounters, or nearly 3.6 claims per second;
- Processed 44,046,045 Fee-for-Service claims in which $8,226,511,514 was approved for payment. This includes 69,674 maternity care claims for which $413,245,790 was paid. For maternity care, we recovered $970,443 through non-live births, duplicate claims, and Audit 35707;
- Paid $7,393,840,006.83 in capitation payments;
- Processed a total of 69,587,745 encounters;
- Processed 55,342,881,834 transactions;
- Produced and mailed 340,701 ACCESS ID cards;
- Screened, ICN’d, imaged and data entered more than 1.5 million paper claims and prior authorization forms;
- Printed/produced and mailed more than 2.8 million pieces of mail;
- Resolved more than 1.1 million claims;
- Answered more than 20,280 calls/requests from providers; and
- Received, tracked, alphabetized and returned 90,672 Trauma Claim Tracking questionnaires.
Controlling Costs

Fraud and Abuse

The Department of Public Welfare is committed to protecting the integrity of the Medical Assistance (MA) Program; eliminating provider fraud, abuse and waste; ensuring that recipients receive quality medical services; and assuring that recipients do not abuse their use of medical services. This objective is met in a variety of ways and accomplished via both retrospective and proactive approaches.

During FY 08-09, over 400 provider reviews were initiated. These reviews included medical record reviews, interviews and on-site visits. Investigations were conducted based on complaints, referrals, tips, as well as the use of random selection methodology. An important source of information that generated leads for reviews came from the Pennsylvania Fraud and Abuse Detection System (FADS). FADS is a specialized relational data base with a decision support tool used for post payment claims review of both providers and recipients. Abnormalities or patterns of misuse are identified for further investigation. Reviews can also be initiated as a result of information obtained through the MA Provider Compliance Hotline. This Hotline facilitates reporting of suspected cases of fraudulent or abusive practices by providers participating in the MA Program or recipients receiving services in either the Fee-For-Service or Managed Care programs. Callers do not have to identify themselves when reporting information. The hotline number is 1-866-DPW-TIPS (1-866-379-8477). Reports of suspected fraudulent or abusive practices can also be anonymously made through OMAP’s web site: http://www.dpw.state.pa.us.

Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

Another key element to program integrity work is prevention; staff regularly participates in training sessions for providers. Providers are encouraged to utilize compliance plans, as well as the self audit protocol to conduct regular review of their records to identify regulatory violations or overpayments. Program Integrity staff enhance their knowledge and skills in fraud, waste, and abuse by attending specialized training conducted by the Centers for Medicare and Medicaid Services Medicaid Integrity Group.

Our comprehensive effort to prevent, detect, and deter improper use of MA funds resulted in the recovery of over $33 million dollars during State FY 08-09, representing an 11 percent increase over the previous year.

Third Party Liability

As a condition of receiving MA benefits, recipients agree to allow MA to seek payment from available third party health care resources on their behalf. All other third party resources must be used before MA dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of keeping MA costs as low as possible. Approximately 29 percent of recipients have third party resources which can be used to cover at least some of their health care costs. Over 11 percent (11.5%) have commercial insurance and 17.5 percent have Medicare coverage. During FY 08-09 over $109 million was recovered and over $636 million was cost avoided.
We are committed to making MA program information readily accessible. The Department’s Web site, [www.dpw.state.pa.us](http://www.dpw.state.pa.us) provides information for MA providers, recipients, and the general public. The site was recently redesigned in an effort to become more user friendly.

The site is now divided into eight functional areas that are located towards the top of the home page. The enhancements were made to make information on the site more accessible to users. These enhancements should make navigation easier for consumers and providers of Medicaid services.

Interested parties can access a broad range of information by clicking on the link to *Information for Families and Individuals*. Resources and links to MA billing information, fraud and abuse, MA regulations, PROMISe™ and more are located in the *Provider Information* section.

Providers are encouraged to access the Web site on a regular basis to stay current on MA Program requirements. Providers can view MA Bulletins that are issued to provide information on operating information and procedures, interpretations, clarifications or explanations of existing regulations, guidelines of a new program direction or policy that does not require regulation and notices of rule changes which require regulatory action.

Another tool used to enhance communications with providers is a newsletter type document entitled *QuickTips*. *QuickTips* are posted on the Web site and mailed to Pennsylvania provider associations to provide useful resources for providers and their office staff. *QuickTips* often include Web links to MA documents that are posted on the Department’s Web site and other Internet sites.

Remittance Advice (RA) Banner Pages/Alerts are issued when there is a need to disseminate information quickly to the provider community. RA Banner Pages/Alerts are contained on the “Address” page of a Remittance Advice Statement or in the form of an insert contained within the RA Statement that is issued to explain the actions taken and the status of claims and claim adjustments processed by PROMISe™ during a particular billing cycle. They can now also be accessed through the PROMISe™ system.
The Pennsylvania Medical Assistance Enrollment Services Web site is available at [http://enrollnow.net](http://enrollnow.net).

This site is available for MA recipients enrolled in, or eligible for the mandatory managed care program, HealthChoices, and the Voluntary Managed Care and ACCESS Plus Programs. The site contains a list and a map of counties where the three programs are operating and a provider directory that identifies providers participating in HealthChoices, ACCESS Plus, and/or Voluntary Managed Care.

The ACCESS Plus Web site is available at [www.accessplus.org](http://www.accessplus.org). This site contains information for enrollees and providers. Handbooks, information about disease management programs, contact information and answers to frequently asked questions are available on this site. The ACCESS Plus Regional Advisory Committee meeting schedule and meeting material is also posted on this site.

COMPASS (Commonwealth of Pennsylvania Access to Social Services) is a Web site that allows individuals to screen, to apply and to renew a broad range of social services. This site [www.compass.state.pa.us](http://www.compass.state.pa.us), serves as a single access point for health care coverage, Food Stamp benefits, Cash Assistance, long term care and home and community based services.

A self-screening questionnaire is available to determine which social services the members of a household may be eligible to receive. The checkmarks in the table below show which services are currently available in COMPASS:

<table>
<thead>
<tr>
<th>Services</th>
<th>Screen</th>
<th>Apply</th>
<th>Renew</th>
<th>MCA</th>
<th>Provider Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care: Medical Assistance</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td></td>
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<tr>
<td>Health Care: CHIP/adultBasic</td>
<td>✔</td>
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<tr>
<td>Cash Assistance</td>
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<tr>
<td>Child Care Works Program</td>
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<tr>
<td>Food Stamps</td>
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<tr>
<td>Energy Assistance: LIHEAP</td>
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<tr>
<td>School Meals</td>
<td>✔</td>
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<tr>
<td>Home and Community Based Services</td>
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<td>✔</td>
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</tr>
<tr>
<td>Long Term Care</td>
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<tr>
<td>ChildPlus for Women</td>
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</tr>
</tbody>
</table>

Organizations such as hospitals, church groups and other community based groups that help Pennsylvania residents apply for social services can apply to be a COMPASS Community Partner. The COMPASS Community Partner View allows organizations to initiate and actively track applications they submit.
Gathering Feedback

The Department receives regular feedback on the Medical Assistance Program from the Medical Assistance Advisory Committee (MAAC). The mission of the MAAC is to provide the Department with advice about access to, and delivery of, quality health care services in an efficient, economical and responsive manner to low-income individuals and families. Participants in the MAAC include the following representatives:

- Consumers and their families
- Physicians and other health care professionals
- Managed Care Plans under contract with the Department
- Representatives of consumer and provider organizations
- Other persons knowledgeable of the health care needs of persons receiving MA

The MAAC has four standing subcommittees: Consumer, Fee-for-Service Delivery System, Long Term Care Delivery System and Managed Care Delivery System. Each subcommittee reviews and discusses various topics related to the specific delivery system and forwards recommendations for program changes and enhancements to the MAAC for consideration.

The Department would like to thank all of the individuals who served on the MAAC and its subcommittees during FY 08-09. Your support and valuable assistance helped to make possible the continuous improvement of the Medical Assistance program.

The Medical Assistance Advisory Committee

Cindi Christ (Chair), Pennsylvania Association of Community Health Centers
Vicki Hoak (Vice Chair), Pennsylvania Homecare Association
Michael Nardone (Ex-Officio Co-Chair), Office of Medical Assistance Programs
Christine Allen, Genesis Healthcare Corporation
Barbara Coffin, Pennsylvania Association of Area Agencies on Aging
Julie Cristol, American College of Nurse-Midwives
Kathryn Crowell, Pennsylvania Chapter, American Academy of Pediatrics
Jonna L. DiStefano, Delaware County Office of Behavioral Health
Marilyn Eckley, AmeriChoice
Mark Goldstein, Pennsylvania Dental Association
Robert Greenwood, Hospital and Healthsystem Association of Pennsylvania
Michelle Jones, Manchester Bidwell Corporation
Coleen Kayden, R.Ph., Pennsylvania Pharmacists Association
George Kimes, Pennsylvania Community Providers Association
Minta Livengood, Indiana County Welfare Rights Organization
Yvette Long, Philadelphia Welfare Rights Organization
Bernard Lynch, Pennsylvania Medical Society
Russ McDaid, Pennsylvania Association of Non-Profit Homes for the Aging
Thomas Peifer, Hospital and Healthsystem Association of Pennsylvania
Mary Ellen Rehrman, Family Training/Advocacy Center for Serious Mental Illness
Nick Watsula, UPMC for You
Kristin Woellmer, County Commissioners Association of Pennsylvania
Dorothy Young, Pittsburgh Welfare Rights Organization
Victor Annan (Ex-Officio Member), Department of Health
Michael Smith (Ex-Officio Member), Department of Aging
Subcommittees

The Consumer Subcommittee

Yvette Long (Chair), Philadelphia Welfare Rights Organization
Leesa Allen (Ex-Officio Co-Chair), Office of Medical Assistance Programs
Linda Bergman, Interested Party
Sonia Brookins, Pennsylvania State Welfare Rights Organization
Sonia Caraballo, Interested Party
Marjorie Jackson Crowder, Interested Party
Mark R. Edwards, Interested Party
Alice Kell, Interested Party
Minta Livengood, Indiana County Welfare Rights Organization
Dorothy Young, Pittsburgh Welfare Rights Organization

The Fee-For-Service Subcommittee

Thomas A. Peifer (Chair), Hospital and Healthsystem Association of Pennsylvania
Bernard Lynch (Co-Chair), Pennsylvania Medical Society
Jolene Calla (Ex-Officio Co-Chair), Office of Medical Assistance Programs
Cheryl Beckwith, Pennsylvania Association of Medical Suppliers
Patricia Bricker, Pennsylvania Academy of Family Physicians
Laraine Forry, Pennsylvania Association of Medical Suppliers
Eric Kiehl, Pennsylvania Homecare Association
Joe Lech, Lech’s Pharmacy
Rick Marsilio, Pennsylvania Council of Children, Youth & Families
Roger Poremsky, PATHS
Stuart Pullen, Pennsylvania Association of Community Health Centers
Kimberly Shank, AmbCoach, Inc.
Deborah Shoemaker, Pennsylvania Psychiatric Society
Betty Simmonds, Pennsylvania Community Providers Association
Vince Splendido, Allied Services
Charles Stucky, O.D., Pennsylvania Optometric Association
Rich Szymkowski, Pennsylvania Association of Resources for People with Mental Retardation
Walter Thomas, DMD, Pennsylvania Dental Association
Jean Yudin, Pennsylvania Nurses Association
The Long Term Care Delivery System Subcommittee

Christine Allen (Chair), Genesis Healthcare Corporation
Vicki Hoak (Vice-Chair), Pennsylvania Homecare Association
Jennifer Burnett (Ex-Officio Co-Chair), Office of Long Term Living
Linda Bergman, Interested Party
Wendy Campbell, Alzheimer’s Association
Barbara Coffin, Pennsylvania Association of Area Agencies on Aging
Kathy Cubit, The Center for Advocacy for the Rights & Interests of the Elderly
James Faust, Claremont Nursing and Rehabilitation Center
Bruce Kinosian, MD, Penn LIFE Program
Melissa Lear, Beck ‘N Call, Inc.
Minta Livengood, Indiana County Welfare Rights Organization
Russ McDaid, Pennsylvania Association of Non-Profit Homes for the Aging
Lisa Shumaker R.N., C., M.A., Pennsylvania Behavioral Health & Aging Coalition
Anne Wantz, Pennsylvania Health Care Association

The Managed Care Delivery System Subcommittee

Marilyn Eckley (Chair), AmeriChoice
Nick Watsula (Co-Chair), UPMC for You
Jeff Bechtel (Ex-Officio Co-Chair), Office of Medical Assistance Programs
Pam Clarke, Delaware Valley Health Care Council
Brandy Derry, Unison Health Plan
Jonna L. DiStefano, Delaware County Office of Behavioral Health
Joe Glinka, Gateway Health Plan
Vicki Hoak, Pennsylvania Homecare Association
Joe Hurd, Interested Party
Bernard Lynch, Pennsylvania Medical Society
Kearline McKellar-Jones, Health Partners of Philadelphia
Connell O’Brien, Pennsylvania Community Providers Association
Malcolm West, Community Behavioral Healthcare Network of Pennsylvania
Kristin Woellmer, County Commissioners Association of Pennsylvania