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Will new initiatives be enough to solve dual eligibles problem?

Dual eligibles account for 15% to 20% of Medicaid enrollment and almost 40% of Medicaid spending, notes **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group that helps to develop and strengthen long-term care programs, and former assistant commissioner in the New Jersey Department of Health and Social Services.

“These are the people who have low income, chronic medical problems, and are aged or have disabilities. They are the most costly subset of people in the country for Medicaid and Medicare to take care

of,” says Dr. Hendrickson.

Expensive subgroup

Total expenditures for Colorado Medicaid’s dual eligibles exceeded \$1.1 billion in 2010, reports **Judy Zerzan**, MD, MPH, the Department of Health Care Policy and Financing’s chief medical officer. “About 13% of our currently enrolled Medicaid clients are dual eligibles,” she adds.

Fifteen states have received grants from the Centers for Medicare & Medicaid Services (CMS) to find strategies to improve efficiency and lower costs for people receiving both

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SC finds rate cuts necessary to protect Medicaid’s optional services

South Carolina Medicaid is taking a variety of innovative approaches to reduce waste in the program, reports **Tony Keck**, the state’s Medicaid director. Optional services including adult vision, adult dental, and adult podiatry have already been eliminated, he says, with some exceptions based on Centers for Medicare & Medicaid Services (CMS) requirements.

“Although we would prefer to offer a full range of services on the fee-for-service side of the business, because we could not restrict eligibility, we had no choice,” says Mr.

Fiscal Fitness: How States Cope

Keck. Some of the announced cuts to long-term care services were restored, he notes, including hospice care for adults and respite care provided through the Community Long Term Care Community Choices waivers. Several Medicaid managed care organizations are still providing these optional services, adds Mr. Keck.

“They do that for a variety of reasons, but we are not sending them the money to do that anymore,” he says.

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Cover story

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Medicare and Medicaid. Colorado will receive \$995,914 over 18 months to develop a plan to assist approximately 80,000 Coloradans who are covered by Medicare and Medicaid, says Dr. Zerzan.

While most of Colorado's dual eligibles age 60 and under report few physical and cognitive limitations, says Dr. Zerzan, about 14.4% account for 50% of the total expenditures for dual-eligibles. Geographically, 82% of dual eligibles reside in the metropolitan areas of the state, she adds.

"Wide spending variation exists from county to county," says Dr. Zerzan. "There is evidence that per capita expenses for dual eligibles in some rural counties are almost double that of dual eligibles in metropolitan areas."

In Colorado, 85% of Medicaid clients, including all dual eligibles, are served through a fee-for-service model, says Dr. Zerzan. There is little coordination of care, she explains, and no effective mechanism for a client's multiple providers to communicate regularly and ensure that the client's needs are being met.

"These issues point to a great need for improved consistency and accountability of the care delivery system across the state," says Dr. Zerzan.

Care management, care coordination, utilization control, and medical planning are needed to reduce expenditures and bring them under some control, says Dr. Hendrickson. In 2008 and 2009, costs for dual eligibles were roughly \$36,000 per person, at a national cost of over \$300 billion dollars, he adds.

"It's a very expensive subgroup. It's also the subgroup that is extraordinarily difficult to manage, because it's hard to get Medicaid and Medicare to talk to one another,"

says Dr. Hendrickson.

The U. S. Department of Health and Human Services' Medicare-Medicaid Coordination Office launched an Alignment Initiative in May 2011, which will give states access to data about Medicare prescription drugs and hospital visits, to improve coordination of care. "It is too early to tell what the new office will accomplish," says Dr. Hendrickson.

Over time, one tangible indicator of success will be the speeding up of access to Medicare data by state programs, he says. "As a state agency, it's still a pull and tussle to figure out how to get Medicare data streamed to you, to better manage these dual eligibles," says Dr. Hendrickson.

Combined administrative systems

According to Dr. Hendrickson, discussions about being either in favor of or opposed to the Patient Protection and Affordable Care Act (PPACA) are missing an obvious point. "We have two massive, parallel health care systems in the country run by the federal government, and the two programs literally don't talk to each other," he says.

Only as part of the PPACA did CMS establish the Medicare-Medicaid Coordination Office to facilitate communication between the two programs, adds Dr. Hendrickson. "The issue is that this is an incredibly wasteful and inefficient system," he says. "For example, why should each state have a separate claims payment system for Medicaid?"

There is no reason why data processing systems for Medicaid couldn't be done on a regional basis as Medicare does, argues Dr. Hendrickson. "Consolidating these backroom operations across states would save an enormous amount of money," he says.

State administrative operations

such as claims payments, provider training, fraud detection, and mailing notices to beneficiaries could be federalized with a considerable savings to people, says Dr. Hendrickson.

The upcoming Medicaid expansion only makes it more evident that the administrative systems should be combined, adds Dr. Hendrickson. "We would all be better off if there was one administrative system that encompassed both Medicaid and Medicare," he says.

Dr. Hendrickson notes that Section 1202 of the PPACA requires state Medicaid programs to pay doctors what Medicare would pay them for 2013 and 2014, and that Medicaid will be expanded to people with higher income limits. "It would make more economic sense to implement these large medical insurance changes in a centralized way, rather than having every state figure out a different way to implement the same requirement," he says.

On the other hand, after talking to both congressional and CMS staff, Dr. Hendrickson has concluded that the approach of having

states manage Medicare isn't going to work.

"There is substantial skepticism by these parties that the states would put into place safeguards for Medicare beneficiaries, give them freedom of choice, and manage them the way CMS would," he says.

For this reason, says Dr. Hendrickson, "I don't see Medicare as a national uniformly administered program devolving onto the states."

Costs are uncontrolled

Until the problem of dual eligibles is addressed in a systematic way, says Dr. Hendrickson, a sizable percentage of Medicaid costs will be uncontrolled. "Whether it's the well-meaning efforts to cut spending in Congress, or grassroots efforts railing against Obamacare, neither of those conceptual approaches deals with how you build integrated long-term living programs that use cost savings to fund case management and drive quality improvement," he says.

Accountable Care Organizations (ACOs) typically focus on acute care services and attempt to mini-

mize hospital costs, notes Dr. Hendrickson, which is a savings to Medicare. "So if you are a state Medicaid program and set up an ACO and medical homes and do a really good job of reducing utilization in hospitals, the major beneficiary is the Medicare program," he says.

Medicare has no incentive to reduce nursing home utilization, since it focuses on reducing hospital utilization, says Dr. Hendrickson, thus putting more people into nursing homes faster.

Reduced hospital utilization results in savings for Medicare, Dr. Hendrickson explains, while Medicaid saves by reducing nursing home and higher-cost home and community-based services.

"Neither of the two programs has any vested interest in helping the other program save money," says Dr. Hendrickson. "Yet, they share in common the group of beneficiaries that create a significant portion of their costs."

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Fiscal Fitness

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"They are making the decision to do it on their own."

Optional services protected

Cuts in optional services will save about \$2.9 million for the remainder of fiscal year 2011, and around \$10 million in state dollars over the course of a full year, says Mr. Keck.

Provider rates were cut by 3% across the board in April 2011 for a \$7.5 million savings, says Mr. Keck, so that optional services would not need to be cut any further. "Our argument to the legislature and the public was that we wanted to put patients first and provider reimbursement second," he says.

As provider reimbursement has been protected for the past three years by state law, says Mr. Keck, "it really was a big win for us, to get that law repealed."

South Carolina Medicaid reimbursement is generous compared with other states and payers, according to Mr. Keck. "While certainly nobody likes to take money away from providers, that reduction made sense, especially when we were facing a \$228 million deficit," he says. "For the next fiscal year, we need to get about \$125 million in state dollars out of what we call the 'provider line.'"

Cost-saving ideas

The agency has not lost any Medicaid providers to date since

the rate cuts were made, reports Mr. Keck. In fact, the agency is actively soliciting ideas from providers to eliminate waste and inefficiency, he adds, in order to mitigate additional rate cuts.

"We are working with providers, and all sorts of interesting ideas have been coming up," says Mr. Keck. "Sometimes, things that we just haven't been doing as a department have increased our costs."

Providers called attention to the fact that Medicaid wasn't allowing a series of surgical and procedure codes to be reimbursed in an ambulatory setting, says Mr. Keck, so the procedures were being done in a more costly hospital setting. "It was a simple mistake," he says. "Just by that change alone, we'll get care reimbursed in a much less expensive

setting.”

The agency reduced administrative costs for its managed care organizations (MCOs), says Mr. Keck. “They had a 12% administrative cap, and we’ve lowered that down to 10.5%,” he reports. “We’ve seen wide variations between our managed care plans, in terms of how efficient they are. We want to reward those that are most efficient.”

The agency also asked MCOs to be more aggressive with care management, says Mr. Keck, and steps are being taken to decrease the “hassle factor” for providers. Medicaid providers often incur costs because of requirements that don’t always add value, he explains.

Providers complained that the Medicaid enrollment system was creating “churn” that caused claims denials and administrative rework, says Mr. Keck, which led to the implementation of Express Lane Eligibility redetermination.

“Instead of re-enrolling those 90,000 kids through a whole bunch of paperwork, we’re able to look at a lot of electronic databases that exist in the state that tell us yes, this child continues to be eligible,” says Mr. Keck. “Until we learn differently, we will automatically re-enroll them.”

This change will prevent thousands of wasted hours not only in Medicaid, but also in managed care plans and in provider practices, says Mr. Keck, because it will keep eli-

gible children on the Medicaid rolls.

Incentives are necessary

The state law prohibiting reduction of provider rates had an unintended consequence, says Mr. Keck, because there was no incentive for providers to give input on cost reduction. “They knew there was nothing the department could do to lower their reimbursement rate, so the status quo was locked in place for several years,” he says.

People need incentives to drive costs out of the program, says Mr. Keck. “One thing you learn in Medicaid pretty quickly is that one man’s waste is another man’s revenue,” he says.

Mr. Keck says that he is very pleased with the feedback the agency is getting from providers. “They clearly understand that it’s about margin,” he says. “What they care about is the bottom line and what they take home.”

Making smart decisions

The agency’s Reduction Assessment Team created a list of opportunities to reduce waste in the system, says Mr. Keck, and more than 40 provider groups have met with the team to share cost-saving ideas.

“There hasn’t been a tradition of using data between providers and the department to make smart deci-

sions,” says Mr. Keck. “One way we can help providers do that is to be much better about sharing data with them. We can help them interpret what it means, and where it does not meet up with norms or best practices.”

After a parent of a child with cystic fibrosis reported that a certain therapy was constantly getting denied, says Mr. Keck, an important change in preauthorization requirements was made.

“As we sat down and talked about it, we came to realize that the provider was doing an excellent job of prescreening,” he says. “Here we were coming around the back end, doing our own review process, when they had already done a more thorough one.”

The agency created a “preferred” category for providers with a proven record of providing cost-effective care, says Mr. Keck, which means these providers don’t need to obtain prior approval for certain high-cost treatments. “That saves them administrative time in trying to get us to approve something, and saves us from reviewing all that paperwork on the back end,” he says.

This reduces hassles for the patient, the provider, and Medicaid all at once, says Mr. Keck. “In almost every case, the best clinical decision will also be the smartest financial decision. Sometimes, we lose sight of that,” he says. ■

Medicaid provider rate cuts on the table? It could be illegal

Rates paid to Medicaid providers are “both a provider and a beneficiary issue,” according to **Byron J. Gross**, BA, JD, an attorney in the Los Angeles office of the National Health Law Program.

“Providers obviously want to be paid more, and Medicaid rates tend to be very low,” he says. “But it’s also a beneficiary issue, because low pro-

vider rates have resulted in low provider participation, resulting in an access to care problem for Medicaid beneficiaries.”

This is a particular problem in California, says Mr. Gross, because specialists accepting Medi-Cal, the state’s Medicaid program, are not available in some counties. As an attorney with Hooper, Lundy &

Bookman in Los Angeles, Gross served as co-counsel on cases challenging reductions in Medicaid rates, including Medi-Cal.

Five lawsuits were filed against the state of California in 2008 and 2009 to stop scheduled reductions in Medi-Cal provider payment rates, says Mr. Gross. These were based on the legal theory that the cuts violated

the federal Medicaid “equal access” statute, he explains, which requires that Medicaid provider payments be sufficient to provide the same access to medical services as the general population.

For years, says Mr. Gross, providers and beneficiaries were generally able to enforce laws establishing a certain bottom level for Medicaid rates by suing under the Civil Rights Act, but this is no longer the case due to several recent court decisions. Cases have developed in California and some other states based on the Supremacy clause, he explains, which holds that if you have a state law that is inconsistent with federal law, the federal law can be enforced.

“In a series of decisions, the Ninth Circuit Court ruled that the state laws cutting back on Medicaid rates in California were inconsistent with the federal law saying that rates need to be sufficient to ensure equal access,” Mr. Gross says.

Since California law was clear that rates had to be tied to costs, says Mr. Gross, if the state was going to set rates below costs they had to give a justification for it. “That was a strong law that we relied on,” he says. “It hasn’t been so clear in other states, because they don’t have as clear an appellate decision on that.”

The issue has gone all the way up to the Supreme Court, says Mr.

Gross, and the case will likely be heard later this year. “Obviously, states are concerned about it,” he says. “There was an amicus brief filed by 22 state attorney generals for the cert petition for the Supreme Court case. Governors want the flexibility to make cuts.”

More enforcement from CMS

Almost all of the Medi-Cal provider rate cuts made in 2008, 2009, and 2010 were enjoined, says Mr. Gross, with the exception of some of the hospital rate reductions. “The hospitals recently worked out a settlement with the state, so that part of the case is resolved. But I would say that 90% of the cuts were enjoined through these various lawsuits,” says Mr. Gross.

One problem in California, says Mr. Gross, was that the state made across-the-board cuts without studying how these would affect access to services.

“The rate reductions were clearly done solely for budgetary reasons, to save money for the state,” he says. “They were making the cuts, then trying to justify them by having the Department of Health Services do studies to show there was no problem with access.”

The court ruled that states need to do this type of analysis before deter-

mining whether cuts can be made, says Mr. Gross. Another problem for California, says Gross, is that the cuts were made without the approval of the Centers for Medicare & Medicaid Services (CMS).

The state Medicaid plan had to be amended to make the provider rate cuts, explains Mr. Gross, which the state is not allowed to do without approval from CMS. “The law is very clear in California. You can’t implement a cutback until you have approval,” says Mr. Gross. CMS has also made this clear through instructions it has issued, he adds.

If the Supreme Court ruling is not favorable, Mr. Gross says that the way CMS reviews state plan amendments will become a more important factor. “That’s a part of the landscape that is changing a little bit,” he says. “Previously, the regulatory framework for that review has been a little vague.”

Mr. Gross explains that proposed regulations may change the way CMS reviews state plan amendments. “If things don’t go well and there is no private enforcement, which we’ve always thought is key because there’s only so much that CMS can do, the hope is that CMS will take a more active role in reviewing proposed rate cuts,” he says.

Contact Mr. Gross at (310) 204-6010 or gross@healthlaw.org. ■

Medi-Cal: Provider rate cuts are necessary

California’s fiscal year 2008-2009 budget enacted several 10% Medi-Cal provider payment reductions, according to **Toby Douglas**, director of the California Department of Health Care Services and the state’s Medi-Cal director. Later in that fiscal year, the legislature lowered those reductions to 5% for pharmacy benefits and long-term care services, amended the reductions for hospital inpatient services to a lesser of two amounts, and low-

ered the reductions to 1% for the other provider payments, he says.

“Court action prevented some of the reductions from going into effect, and the state was unable to realize the full amount of budgeted savings,” says Mr. Douglas. “However, the other reductions remain in place today.”

No rate reductions were enacted in fiscal years 2009-2010 or 2010-2011, Mr. Douglas reports. However, the state’s governor

recently signed legislation to implement new payment reductions of 10% for nursing and subacute facilities and intermediate care facilities for the developmentally disabled, and adjust current provider payment reductions to bring them up to 10% for fiscal years 2010-2011 and 2011-2012.

“The reductions are necessary in an era of dwindling resources and budget deficits,” says Mr. Douglas. “Medi-Cal, as the state’s second larg-

est general fund expenditure, must be part of the solution.”

More flexibility sought

Mr. Douglas says that he does not believe the payment reductions have negatively affected Medi-Cal beneficiaries’ access to services. He says that it is also important to note that the recently enacted legislation, which provides the authority to implement new payment reductions, requires the director of the Department of Health Care Services to determine compliance with applicable federal requirements before implementation.

“We are dedicated to ensuring adequate access. We’ve approached the issue most recently through California’s Medicaid Section 1115 waiver,” says Mr. Douglas. This allows the state to transition tens of thousands of seniors and people with disabilities from the current fee-for-service program into managed care, he explains.

Beneficiaries will obtain assistance with navigating the health care system, says Mr. Douglas, and will benefit from getting a medical home that ensures provider network adequacy and specialty services. “This increased access to services will help to improve health outcomes,” he

adds.

With growing enrollment in Medi-Cal and rising costs for providing medical services, including prescription drugs and inpatient and outpatient services, says Ms. Douglas, the state must find ways to manage the program while living within its means.

“We are seeking to obtain more flexibility from our federal partners to make targeted reductions in benefits and reimbursements rates that would provide critical savings for the state,” he says.

Contact Mr. Douglas at (916) 440-7400 or Toby.Douglas@dhcs.ca.gov. ■

Build primary care capacity now for Medicaid’s new eligibles, expert says

When you consider the newly eligible population coming onto your state’s Medicaid program in 2014, remember that “those 32 million people out there are already being seen somewhere. They are being seen by a range of safety net providers,” says **Georges C. Benjamin**, MD, FACP, FNAPA, FACEP(E), executive director of the American Public Health Association in Washington, DC.

Some are getting great care, some are getting little or no primary care, while others are being seen for episodic care only in emergency departments, says Dr. Benjamin. “The important point is that many of those 32 million people are probably being seen in the most inefficient manner possible,” he says.

With that in mind, says Dr. Benjamin, state Medicaid directors need to take a good, comprehensive look at what the program’s primary care capacity actually is. “If we just let the market do it, it won’t work,” he says. “You have to do some serious planning and work in a proactive way with the medical and

nursing community.”

Address maldistribution

Dr. Benjamin recommends working with the state’s medical, nursing and physician’s assistant schools to build capacity. Maldistribution is a problem both in the nation and within states, he says, and can be addressed with incentives such as reimbursement policies or scholarships.

Some practitioners cap the number of Medicaid patients they will accept due to poor reimbursement, notes Dr. Benjamin. “It’s obviously better financially to have a person in a private plan that is going to pay more, than someone in Medicaid or Medicare,” he says. “By increasing reimbursement for the primary care providers in public plans, they can offset some of that.”

Reducing payment delays and required paperwork can help prevent the “churning” of patients, says Dr. Benjamin. “One of the challenges we have in the Medicaid program today is the patients who go

on and off the rolls,” he says. “That not only involves the patient, it also impacts the physician when the patient shows up, and they are no longer in the program but actually are still eligible. That affects reimbursement.”

There also is no reason why a patient’s cardiologist, pulmonologist, or endocrinologist could not be designated as the patient’s primary care practitioner in selected cases, according to Dr. Benjamin. He gives the example of a patient with severe heart disease, mild diabetes, and mild pulmonary disease, whose major problem is cardiovascular.

“You have to look at the fact that the patient probably spends more time in the cardiologist’s office than they ever would spend in their primary care physician’s office,” he says.

Absorbing additional patients

Dr. Benjamin notes that as a result of Massachusetts’ implementation of health care reform, the volume of patients seen in Federally Qualified Health Centers (FQHCs) in the

state grew. “Not only has their reimbursement gotten better, because they get paid for many patients they weren’t getting paid for before, but they also have a really phenomenal capacity to grow and expand,” he says.

With good management and continued fiscal support, says Dr. Benjamin, FQHCs can continue to absorb additional numbers of patients.

“I’m not saying we don’t have a physician shortage, or that it won’t be a problem going forward,” says Dr. Benjamin. “But I don’t think we should let it become an excuse for not covering people. All we are really doing is creating a system where people are getting seen in a more efficient way.”

The most important thing for state Medicaid directors to do right now, advises Dr. Benjamin, is to sit

down with other health planners in the state, including medical and nursing societies. “Get a good feel for where people are really being seen today, and how that might change in an environment where everyone has an insurance card,” he says. “The assumptions are often not obvious.”

Link patients to services

Dr. Benjamin says that in his former role as Secretary of the Maryland Department of Health and Mental Hygiene, there were some significant barriers to getting practitioners into the health plan when the state switched to mandatory Medicaid. “We had to work very hard to get all of their providers into an acceptable health plan. It required a proactive approach to do that,” he says.

A large percentage of Medicaid patients was already being seen in

the state’s mental health system, says Dr. Benjamin, and were receiving their primary care and episodic health services inefficiently.

These Medicaid patients were relatively young and healthy, says Dr. Benjamin, but they had a significant mental health problem that needed to be addressed. “You’ve got to sit back and look at where everybody is being taken care of,” he says. “Sometimes, you have to craft new systems to take care of them.”

Other times, says Dr. Benjamin, it’s a matter of linking patients to existing services. “You may need to create wraparound services or provide case managers so these folks can get their appointments and be seen,” he says. “The public health system is very good at doing that.”

Contact Dr. Benjamin at (202) 777-2742 or georges.benjamin@apha.org. ■

NPs, PAs are essential to build primary care access

Ensuring access to primary care in Medicaid is going to take a “multi-pronged strategy,” according to **Julia Paradise**, MSPH, an associate director of the Kaiser Family Foundation’s Kaiser Commission on Medicaid and the Uninsured and lead author of the organization’s March 2011 brief, *Improving Access to Adult Primary Care in Medicaid*.

“This includes more fully deploying all our primary care providers — nurse practitioners and physician’s assistants, as well as doctors,” she says.

Ms. Paradise notes that an October 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, documented the high quality of care provided by nurse practitioners, and recommended state and federal actions to clear the way for them to

practice to the full extent of their training.

In light of this, says Ms. Paradise, states can free up additional primary care supply in the immediate term by removing restrictive scope-of-practice regulations that many have on the books.

“We have great examples of high-

“Increased support for primary care providers who participate in Medicaid is one lever for securing more capacity in the program.”

performing health care systems, including the VA health system and the Geisinger Health System, in which nurse practitioners are integral to the delivery of primary care,” says Ms. Paradise.

Ms. Paradise adds that the concern about access to primary care in

Medicaid is “one facet of the bigger reality — that we need a larger primary care workforce than we currently have.”

The maldistribution of health resources compounds this problem for low-income communities, says Ms. Paradise, because there are more providers than needed in some geographic areas and serious shortages in others.

“Increased support for primary care providers who participate in Medicaid is one lever for securing more capacity in the program,” says

Ms. Paradise. “The two-year boost in Medicaid payment rates for primary care physicians, as provided by the health reform law, speaks directly to that.”

Contact Ms. Paradise at (202) 347-5270 or jparadise@kff.org. ■

Medicaid may be more popular than you realize

Nearly half of Americans (47%) oppose spending reductions for Medicaid, according to an April 2011 survey of 1502 adults conducted by The Kaiser Family Foundation and the Harvard School of Public Health.

Robert Blendon, ScD, professor of health policy and political analysis at the Department of Health Policy and Management at the Harvard School of Public Health in Boston and director of the Harvard Opinion Research Program, which assesses attitudes about major domestic public policy issues, says he wasn't too surprised by this finding.

"Medicaid has broader support than people in the field might realize," says Dr. Blendon. "It's not that people don't value this program. When Medicaid was associated much more narrowly with public assistance, it was less popular."

There is now a significant appreciation for the program, says Dr. Blendon, because Medicaid covers a much wider range of people, including nursing home residents, the disabled, and the newly unemployed. "At the moment, I believe Medicaid is much more popular than many other functions in the state, with the exception of public education," says Dr. Blendon.

Make it personal

Dr. Blendon says that although people do not want cuts to

Medicaid, they also don't want their taxes raised. "If you are a Medicaid director, the good news is that people don't want to hear about cuts," he says. "That doesn't mean they are willing to see their sales tax or income tax rise."

Dr. Blendon recommends sharing stories of how the Medicaid program has helped individuals in your state. "The more you describe them on a personal basis, the more concerned people will be about cuts," he says. "Talk about the people who are helped by the program, not the aggregate program."

Medicaid directors should convey the image of a popular program that is helping many people in their state, Dr. Blendon advises. "Directors often talk about these things as if it's just a budget number," he says. "They should lead with their strength, of how many individuals in the state are getting help."

At the end of the day, however, people will still be against tax increases, according to Dr. Blendon. "These are popular programs, but you need a lot of money raised to keep them going," he says. "So there will be battles, but the Medicaid director should know that they are at least leading with a program that's popular."

Cuts may be moderated

Evidence of public support for Medicaid can potentially save the

program from being cut, at least in some cases, according to Dr. Blendon. "Legislative people have some sense of things that are less popular or more popular. In general, things that are more popular do better," he says, giving the example of the National Institutes of Health.

"They had a cut, but nowhere near that of other agencies, and part of that is because medical research is very popular in the U.S.," says Dr. Blendon. "Also, a lot of groups will lobby for services, so states will feel a lot of pressure."

Dr. Blendon says, though, that as either the second or third largest program in the state, and possibly the fastest growing program in the state, Medicaid is simply too big to ignore. "You may have a program that is more popular than you thought it was, but people are still going after it because they can't make up for it without a tax increase," he says.

Medicaid is so large within the state's budget, says Dr. Blendon, that public opinion can only moderate cuts to some degree. "It isn't as though you can close down state institutions and not cut Medicaid," he says. "If you really have a large shortfall, and if you are not going to raise revenues, it's hard to find other things that are large enough to balance the budget."

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States making smart use of technology with enrollment

States have achieved substantial progress in streamlining Medicaid enrollment and renewal processes for children, but have achieved less progress in this area for adults, according to **Samantha Artiga**, MHSA, a principal policy

analyst at Kaiser Family Foundation (KFF) in Menlo Park, CA.

Nearly all states have eliminated interview and asset test requirements for children applying for Medicaid and the Children's Health Insurance Program (CHIP), as

noted in the KFF's January 2011 brief, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011*.

While an increasing number of states had adopted presumptive eligibility and 12-month continuous eligibility for children, according to the report, for parents, seven states still required an interview at application, five required one at renewal, and more than half applied an asset test.

“Continued streamlining of procedures and increased alignment of procedures between children and adults will be important for successfully enrolling newly eligible individuals in a timely manner, and will facilitate the integration of enrollment for Medicaid and Exchange coverage under health care reform,” says Ms. Artiga, one of the report’s authors.

Innovative technology use

States are increasingly using technology in innovative and cost-effective ways to improve application, enrollment, and renewal procedures, reports Ms. Artiga.

For example, in 2010, a growing number of states began using electronic data matches to obtain or verify information at enrollment and/or renewal, she says.

For example, in 2010, twenty-

nine states adopted the new option to verify citizenship status by relying on an electronic data match with the Social Security Administration, according to the January 2011 report. Also, six states implemented Express Lane Eligibility initiatives that enable states to use a finding of income and other eligibility criteria for another public assistance program as evidence of eligibility for Medicaid or CHIP, adds Ms. Artiga.

Thirty-two states now offer an electronic Medicaid application, says Ms. Artiga, while 14 states offer online renewals. “A few states, such as Wisconsin and Oklahoma, have developed more robust online systems with application and account management capabilities,” she says. “These are more reflective of the enrollment systems envisioned and required under reform.”

Prepare for expansion

States need to continue to streamline enrollment and incorporate technology into their Medicaid and CHIP eligibility systems to be ready for the coverage expansions in 2014, explains Ms. Artiga, to meet the requirements for an integrated, streamlined, technology-supported

enrollment system for Medicaid, CHIP, and Exchange coverage.

“The federal government has taken several steps to support states in this area,” says Ms. Artiga. For instance, she says, enhanced federal funding is offered for the development and operation of state Medicaid eligibility and payment systems that meet specified standards, and guidance has been issued to help states design and implement the information technology infrastructure outlined.

In February 2011, adds Ms. Artiga, the U.S. Department of Health and Human Services awarded innovator grants to Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a consortium of New England states to create models of information technology systems for operating state-based exchanges that can be shared with other states.

“Many states will need to make large-scale upgrades and improvements to their Medicaid eligibility systems that will require significant lead time,” says Ms. Artiga. “It is important to begin efforts now.”

Contact Ms. Artiga at (202) 347-5270 or SamanthaA@kff.org. ■

Data on “young” medical homes is still new, but trends looking good

There isn’t a lot of data on the cost savings of state medical home initiatives because the state pilots and demonstrations are still new, according to **Mary Takach**, MPH, RN, the lead researcher on the Washington, DC-based National Academy for State Health Policy’s Medical Homes II Consortium project.

Many medical home programs have very comprehensive evaluations underway, says Ms. Takach, but these are not yet complete. Rhode Island is currently evaluating

its data in order to report the outcomes later this year, she notes.

“The two-year window of their pilot ended in October 2010, and evaluators are looking at the data now,” she says. “Because so many of these initiatives are so young, we don’t know if they are meeting cost and quality goals.”

However, Ms. Takach adds that several state Medicaid medical home programs have reported trends as part of their annual reports or reports to the state legislature. “This provides some evidence of trends

that states are seeing, which might be informative for others to know about,” she says.

North Carolina’s program has reported data demonstrating the potential for medical homes to cut the rate of spending, says Ms. Takach. The program saved over \$231 million in state fiscal years 2005 and 2006, according to a 2007 report prepared by Mercer, a consultant specializing in the analysis of program effectiveness.

“Not only were they able to slow the rate of growth, but they also saw

some improvement on health outcomes for asthma, for instance,” says Ms. Takach.

Signs are encouraging

While North Carolina and Oklahoma have statewide medical home initiatives in place, says Ms. Takach, others states have implemented smaller demonstrations limited to one region or subpopulation. “In the broad-based programs, there are encouraging signs that this may be a way to tame soaring costs growth in Medicaid,” says Ms. Takach. Oklahoma reported a decline in per capita member costs of \$29 per patient per year, from 2008 to 2010, she notes.

Still, states may be taking a “wait and see” approach until more comprehensive data is available, says Ms. Takach. “If researchers were to look at this data, I don’t know if they would call it robust or evidence of success,” she says.

While North Carolina and Oklahoma provide encouraging evidence that reforms can be done in a budget-neutral way and even produce some savings, says Ms. Takach, states may need more convincing that the upfront investment in infrastructure will really pay off.

“Still, the word must be getting out about these promising trends. We are seeing new legislation being passed, despite budget deficits,” says

Ms. Takach.

Primary care demand

While Oklahoma previously had a very flat enrollment rate of Medicaid providers, says Ms. Takach, 244 additional physicians enrolled after the program was implemented. “Reforming payment and delivery system can attract new providers,” she says. “That is something for other states to keep in mind as they face the incredible demand for primary care that will be placed on state Medicaid programs.”

Colorado has reported improvement in access to primary care for children, says Ms. Takach, after a statewide medical initiative for children enrolled in the Children’s Health Insurance Program was implemented. While only 20% of the state’s pediatricians accepted Medicaid patients in 2006, the year the program was rolled out, says Ms. Takach, 96% now accept Medicaid.

“Before the program was rolled out, they had a very hard time finding pediatricians that would accept Medicaid,” says Ms. Takach. “That is a good sign that the medical home approach is satisfying physician expectations.”

Lowest hanging fruit

When it comes to cost savings from medical homes, Ms. Takach

says that the “lowest hanging fruit” is reduced inappropriate utilization of services, including decreased ER use and 30-day readmission rates.

Vermont reported mixed data on its medical home pilot, however, with decreased inpatient costs and ED use in one region and slightly increased costs in another region.¹ “It’s too early to figure out why costs fell in one area of the state and rose slightly in another area of the state,” says Ms. Takach. “It’s going to be a ‘wait and see,’ as they are able to evaluate the data.”

Certain expenditures are expected to increase initially with a medical home program, adds Ms. Takach, such as primary care visits and prescription drugs. It’s not realistic to expect to see a return on investment in a year or even two years, she says.

“Maybe in three years, you can see some of these transformational changes taking hold,” says Ms. Takach. “It is really hard to manage expectations around these programs. It does take time, and that time isn’t being given in many cases.”

Contact Ms. Takach at (207) 874-6524 or mtakach@nashp.org.

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Medical homes may give better quality of life to chronically ill

States can “drastically improve” the health of their sickest Medicaid beneficiaries by taking advantage of the new option in the Patient Protection and Affordable Care Act to offer “health homes” to enrollees with chronic conditions, according to **Renée Markus Hodin**, director of the Integrated Care Advocacy Project at Community Catalyst in

Boston, MA.

This can be done, Ms. Hodin says, by improving the coordination of medical care and connecting patients to appropriate community and social supports.

“States that have implemented these kinds of health homes have seen improved quality of life for chronically ill patients,” reports Ms.

Hodin. Medicaid enrollees with asthma in North Carolina’s medical home program, Community Care of North Carolina, experienced 17% fewer asthma-related ER visits and 40% fewer asthma-related hospital admissions between fiscal year 2003 and 2006, she notes.

North Carolina’s Medicaid medical home program saved the state

between \$154 and \$170 million in 2006 alone, says Ms. Hodin, while Illinois saved \$220 million in the first two years after its Medicaid medical home program was fully implemented.

“The health home option offers a viable alternative to the kinds of draconian Medicaid cuts we’ve seen in Arizona, which eliminated coverage for some heart, liver, lung, pancreas, and bone marrow transplants,” says Ms. Hodin. It also offers an alternative to less drastic cuts in other Medicaid benefits, she adds, and reductions in already-low Medicaid

provider reimbursement rates.

Not much of a downside

“Truly, there are not many downsides for states in electing to take this option,” says Ms. Hodin.

In order to receive approval from the Centers for Medicare & Medicaid Services for the state plan amendment required to receive the enhanced federal match dollars associated with the health home option, she notes, states must provide at least six key services to eligible enrollees. These are comprehensive care man-

agement, care coordination and health promotion, comprehensive transitional care from inpatient to outpatient settings, individual and family support, referral to community and social support services, and the use of health information technology to link services.

“States have flexibility in determining the reimbursement structure,” says Ms. Hodin. “They have a number of options to choose from for provider arrangements that can qualify as health homes.”

Contact Ms. Hodin at (617) 338-6035 or hoden@communitycatalyst.org. ■

Don't allow Medicaid program's budget impact to be overstated

The impact of Medicaid on state budgets is often overstated, according to a March 2011 report from the Georgetown University Health Policy Institute's Center for Children and Families in Washington, DC.¹

“A lot of discussions about Medicaid right now are very politically charged,” says **Joan Alker**, one of the study's authors. “We think it's important to ensure that they are fact-based.”

There is no question that states are currently facing severe fiscal challenges, says Ms. Alker, co-executive director at the Georgetown Center for Children and Families and a research associate professor at Georgetown University's Health Policy Institute, but it's important to put Medicaid costs into context.

“We need to look at this from a historical perspective. These kind of cycles have happened before,” says Ms. Alker.

According to the report, state spending on Medicaid actually declined by 3% in 2009. State Medicaid directors need to pinpoint the causes of increased costs in their

Medicaid programs, she advises, which are likely due to enrollment growth and not cost growth.

This is an important point, says Ms. Alker, because enrollment growth will presumably slow down when the economy improves. It also underscores the fact that Medicaid is already a very efficient program, she adds.

“Some states are considering turning to private companies to reduce costs,” notes Ms. Alker. “We know that health insurance in the private sector costs more than Medicaid, so that raises some yellow flags.”

Offer 'Medicaid 101'

Some individuals may wrongly assume that particular numbers cited refer to state dollars only, warns Ms. Alker, when in fact the figure includes the federal Medicaid matching funds states receive. “When the federal share gets thrown in, it makes the program sound like more of a budget buster than it is,” she says. “It also contributes to the dynamic of Medicaid competing with other priorities.”

There has been a significant amount of turnover in state legislatures recently, adds Ms. Alker. “So when numbers are being thrown around, one can't assume that a legislator is going to intuitively ask the question, ‘Are these just state dollars, or both state and federal?’”

For this reason, Ms. Alker advises state Medicaid directors to “do a little Medicaid 101.” Explain the role of federal matching dollars, she recommends, with some analysis of the way the state's Medicaid program has changed over time.

“This is particularly important now, with the enormous amount of turnover and the ideologically charged debates,” says Ms. Alker. “Cite the percentage of Medicaid spending as a share of the state general funds. I think that may be a surprising number to a lot of people.”

Contact Ms. Alker at (202) 784-4075 or jca25@georgetown.edu.

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Medicaid payment reforms are desired, but states face obstacles

States are poised to take advantage of the payment reform approaches outlined by the Center for Medicare and Medicaid Innovation

(CMMI) established by the Centers for Medicare & Medicaid Services (CMS), says **Anne Gauthier**, a senior fellow at the Washington, DC-based National Academy for State Health Policy (NASHP).

“The Center is able to offer a waiver, if you will, of budget neutrality,” she says. “It offers funding to make an investment in payment and delivery system change, which is often needed for a number of these reforms.” That is something that has not been available to states in the traditional Medicaid waiver process, says Ms. Gauthier.

On the other hand, Ms. Gauthier acknowledges that limited resources are a potential obstacle for states. “There are so many things they are concerned with — not only the day to day running of the program and the budget deficits, but implementing health reform,” she says. “There is only limited bandwidth available to do some of the other changes available to them.”

States have to figure out what

they’re going to do first, and when, says **Neva Kaye**, managing director for health system performance at NASHP, and consider whether they are going to work with the private sector.

“Whenever you are working with the private sector, it takes more time to reach the level of agreement to really do it well,” says Ms. Kaye. “It can be difficult to capitalize on some of those opportunities, although once they get there, it could be fabulous.”

Politics is another potential obstacle to states moving forward with payment reform, according to Ms. Kaye. “It’s not just politics with a capital ‘P,’ as in ‘We’re not going to implement health reform,’ but also what solutions are going to work within a state,” she says. “Every state has its own set of resources and platform it’s trying to move from.” That simply makes some reforms viable in some states and not in others, explains Ms. Kaye.

Payment reform means you are making changes to the way providers are paid, says Ms. Gauthier, which means there are winners and losers. “That’s what makes the politics so very difficult,” she says. “It means some providers will get less money and other providers will get more money.”

In other cases, states may simply need more time to implement payment reform approaches, says Ms. Kaye. “You have the law and you have the guidance that CMS releases. But states still have to figure how they are going to develop something that fits that guidance within that state,” she says. “That simply takes time.”

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