State Health Watch

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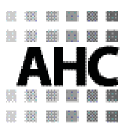
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Is long-term care a "ticking time bomb" for Medicaid programs?

The growing cost of long-term care services in Medicaid, which currently accounts for 32% of total Medicaid spending, could double or even triple by 2030, according to a June 2010 report from the Washington, DC-based Deloitte Center for Health Solutions, *Medicaid Long-term Care: The Ticking Time Bomb*.

If current trends in long-term care spending continue, Medicaid could reach levels close to 40% as a percentage of state operating budgets in some states. The researchers say that the expansion of Medicaid in 2014 will exacerbate this spending trend.

"While the findings in the report were generally not unexpected, certainly the magnitude of the financial impact on state Medicaid and overall state budgets was surprising," says **Bob Campbell**, vice chairman of Deloitte and head of the firm's state government practice. Mr. Campbell helped lead the study on Medicaid long-term care.

The Deloitte team knew these costs were a major issue for states, but had not developed a forecast with this level of detail until now. "In addition, the wide variability among states in medical management approaches is very interesting," says Mr. Campbell.

*See **Long-Term Care** on page 2*

Idaho Medicaid leaves no stone unturned to fill $247M budget gap

There is no question that Medicaid programs can use all the legitimate cost-cutting ideas they can get, but Idaho has gone the extra mile.

"Idaho's economy is not good and has not picked up. Our unemployment rate is still pretty high," says **Leslie Clement**, administrator of the Department of Health and Welfare's Division of Medicaid. "We were in really good shape before the economy went south, but it dropped more dramatically than other states. We qualified for the highest FMAP tier that you can get."

The state's Division of Medicaid launched a new website to solicit public input to address a projected $247 million budget deficit for FY 2011. "To put this in perspective, our Idaho Medicaid budget is about $1.5 billion total funds," says Ms. Clement. "And we are looking at about a $71 million general fund shortfall, with a total of $250 million shortfall for the existing state fiscal year. It is huge, and is not doable."

Fiscal Fitness: How States Cope

The program already has made many provider pricing reductions and some benefit reductions. Initial budget reductions began in FY 2009,

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Long-Term Care

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He says that Medicaid cost management will continue to be a major focus for states, given that Medicaid comprises such a large percentage of state budgets, of which long-term care is the fastest-growing portion.

Many changes coming

The downstream impact of the Patient Protection and Affordable Care Act on long-term care in Medicaid "is huge," according to **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group that helps to develop and strengthen long-term care programs. Dr. Hendrickson has administered Medicaid long-term care programs and has conducted research and fiscal analyses on the cost of Medicaid, Medicare, and other government health programs.

"The best way to see what's going to happen in the next few years is to take a look at the provisions in the act," Dr. Hendrickson says.

"On the one hand, we have a huge expansion of Medicaid eligibility to include some 15 to 16 million persons," says Dr. Hendrickson. "This is being paid for by a great federal bribe in the form of enhanced federal match for the rest of the decade."

On the other hand, the basic benefit package, as described in Section 1302, does not include long-term care or home and community-based benefits. This means that no enhanced federal rates are available for long-term care.

"We are already in a situation where demand for services is increasing, while states are cutting long-term care budgets and provider rates," says Dr. Hendrickson. "At the same time, the feds are continuing an incremental expansion of long-term care benefits."

In addition to extending the Money Follows the Person program through 2016, the 1915(i) Home and Community-Based Services (HCBS) state plan option was revised to broaden the scope of covered services. Also, the Community Living Assistance Services and Supports Act, a national voluntary insurance program for purchasing community living assistance, was established.

"The Secretary of [the Department of Health and Human Services] is charged with developing three 'actuarially sound' plans that folks can pay premiums to," adds Dr. Hendrickson. "That's a substantial help to folks with disabilities who want to be living in the community."

There is also the possibility of making HCBS a state amendment, which would further break down the distinction between waivers and state plan optional services.

"All of this gets started small at first, but could have a lot of use over the next four or five years," says Dr. Hendrickson. Here are other trends in Medicaid long-term care services:

• **Emphasis on an improved workforce.**

The legislation established a National Health Care Workforce Commission to give grants to states that provide new training opportunities for direct care workers employed in long-term care settings. "They are trying to get some seed money out to encourage states to put on those programs," says Dr. Hendrickson.

• **More transparency.**

In recent years, states had difficulty obtaining financial and quality information on nursing home chains. This is expected to change, due to new disclosure requirements on the financial structures of nursing homes.

A person who owns a nursing home may also have an imaging or physical therapy company. The ownerships of all of the subsidiary

companies may be masked, or it may be unclear who owns what percentage.

"What you get into is a series of interlocking businesses," explains Dr. Hendrickson. "You don't really know if the home is operating in the most cost-efficient manner, because you are dealing with related third-party companies."

States will now be able to access this information without resorting to subpoenas or going to court. "In the past, that's what they had to do to break up the entanglement," says Dr. Hendrickson. "The feds are cracking down on this and are coming out with disclosure laws."

• **An increased emphasis on quality.**

The federal government is setting up a new quality assurance and performance improvement program. States are directed to audit selected nursing homes every six months.

"The nursing homes may end up on a list they don't want to be on — the homes that, in their opinion, need the most improvement," says Dr. Hendrickson. "We are seeing a continuing push on quality. That is a tide that has not abated yet."

• **A growing emphasis on the direct care work force.**

"I think that the relationship between staffing and quality is now acknowledged. That is coming through with a vengeance," says Dr. Hendrickson. "For example, most of the pay-for-performance programs across the country have a staffing measure in them."

The federal government is now requiring facilities to post staffing characteristics on the Centers for Medicare & Medicaid Services (CMS)' Nursing Home Compare website. "You see a much more determined push at the federal level to emphasize the importance of staffing in nursing homes and to make that information available to the public," says Dr. Hendrickson.

The Government Accounting Office is currently studying the Five-Star Quality Rating System for nursing homes used by CMS. "It is an odd sort of rating system, as only 10% get in the top star, not 20% in each star. So, the other 90% are spread over the bottom four stars," says Dr. Hendrickson. "There have been a lot of comments on that, and Congress wants to get an independent view."

Dr. Hendrickson says that nationally, he sees "a merging between the quality-of-care folks and the work-force folks."

Coalitions that are set up to support direct health care workers, such as the Service Employees International Union, "are coming together with some of the culture change folks to make nursing homes more livable," says Dr. Hendrickson. "And the nexus of that, where those two circles overlap, is in staffing."

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Fiscal Fitness

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resulting in a reduction of about $20 million in general funds.

"The next year, this general fund reduction amount doubled," says Ms. Clement. "The original appropriation was further reduced, after an updated economic forecast showed state revenues declining."

Medicaid could not complete the 2010 year within budget without holding the final three weeks of claim payments. "This pushed $25 million into the current year, which added to the magnitude of this year's budget challenge. And now we are at it again," says Ms. Clement. "After two years of doing cutbacks, to be at this point in another fiscal year is just daunting."

Lawsuits target access

Over the past two years, Idaho Medicaid's rate cuts were applied across a range of providers, including hospitals, nursing homes, and intermediate care facilities. Physician and dental rates were frozen. "This year, legislators directed us to freeze all rates and ensure that none were above Medicare rates," says Ms. Clement. "Medicaid will follow that direction, with some exceptions."

Idaho currently pays some primary care doctors slightly more than Medicare rates to protect access. "We probably need to continue that to hang on to our participation. We also have work shortage issues here for primary care docs," notes Ms. Clement.

No further provider rate cuts are planned at this time, due partly to lawsuits. Idaho had initiated a methodology and rate reduction change to one of its community-based services, but was stopped by an injunction.

"Once Medicaid providers begin filing lawsuits, others see it as a great opportunity to jump on that bandwagon to stop the agency from making further pricing reductions," says Ms. Clement. "It is clear that we cannot arbitrarily cut rates. We don't want to do anything that creates a health and safety issue. We are given legislative direction and also have to comply with federal law. You can't make a policy change that limits access to medical service."

One lawsuit involved a group of providers which claimed that a pricing reduction for home and community-based services wasn't in compliance with federal Medicaid requirements for access. "We disagreed with them and continue to disagree. We entered into a settlement conference with them, and we are now working with them to do a cost study," says Ms. Clement.

Another lawsuit was dismissed, because Idaho Medicaid was able to demonstrate that access had been carefully monitored after the rate reduction, and no problems were identified, Ms.Clement says.

"We had gone through the state plan amendment approval [with the Centers for Medicare & Medicaid Services], and we were on solid ground," says Ms. Clement. A third lawsuit is still outstanding and involves a pricing reduction made several years ago.

Cost-cutting changes

Instead of pursuing further rate reductions, Idaho reduced the maximum hours for which certain benefits can be billed. "During the last legislative session, we told legislators that if we were not going to receive the necessary appropriation to fully fund Medicaid, we were at a point where we needed to consider eliminating certain benefits," says Ms. Clement. "Even though we believed we were at the point, legislators just weren't ready to make that policy decision. Instead, they asked us to continue to find other ways to reduce costs."

In Medicaid's 2011 appropriation bill, legislative intent language identifies a number of cost reduction approaches. These include price freezes, price reductions, limiting prices to Medicare rates, and reducing benefits. Management strategies include selective contracting, waivers, standardized assessments, and other benefit modifications.

Here are some of the management strategies that were implemented to reduce costs:

• **The Medicaid provider tax methodology was used to reduce general fund expenses for hospitals and nursing homes**.

"We had already established a hospital assessment through state statute and an approved state plan amendment, but we increased the percentage of the tax this year to save $25 million in state general funds. We are in the process of implementing a similar approach for nursing homes and hope to save about $10 million," says Ms. Clement. "Those are the two areas that we are anticipating the biggest reductions."

• **Edits were made to the program's claims system to improve program integrity.**

One goal is to avoid duplication of benefits, which was occurring primarily in the developmental disability and mental health areas.

• **A transportation broker model was implemented for non-emergency medical transportation.**

• **The program's dental plan administration was outsourced to a commercial health plan, under a managed care arrangement.**

"That was a really successful change that we made a couple years ago. It expanded access for the majority of our Medicaid enrollees, and we just added our disabled population to that," says Ms. Clement. "We now have the best access rate in the country for kids. So, that was a positive thing to do, along with all of the draconian measures we had to implement."

Ideas solicited

To be sure no stone was left unturned in finding ways to trim costs, "We went through an enormous public participation effort," says Ms. Clement. Cost-reduction surveys were posted on the department's website, and both providers and non-providers were asked to respond.

The online survey included questions about reimbursement methods, managed care, waivers, and other benefit and pricing questions to elicit ideas to reduce costs. More than 600 surveys were completed.

"We are compiling all of the recommendations and suggestions and will post the feedback we received on our website. We will then start writing temporary rules to see if we can start chipping away at that shortfall," says Ms. Clement.

In addition, more than 30 meetings were held with every type of provider group in the program, from nursing homes to personal care agency providers. The goal was to elicit ideas for how to reduce program costs while maintaining a viable program.

Each meeting was scripted to share the same budget overview information and ask the same cost reduction questions. "We also asked that providers focus on their own programs and not suggest reductions in other programs," says Ms. Clement.

The input did not include many pricing changes that will yield short-term savings, but there were good ideas discussed about changing reimbursement methodology that might help program sustainability over time.

Other suggestions involved efficiencies. While these won't necessarily reduce Medicaid benefits costs, they do reduce the administrative costs incurred by providers. "And that is a good thing, when you are asking them to make do with less," says Ms. Clement.

As for wiping out the $247 million budget shortfall, Ms. Clement says, "we don't think we will get very far into that, but we're doing what we can do. We made a good effort to sustain the program in its current form without eliminating any benefits, but I think we will come up short. Legislators will need to determine if they can fund the gap that remains."

For the most part, suggestions from non-providers weren't feasible or weren't in compliance with federal requirements. "For the general public to understand Medicaid

law is asking a bit much," says Ms. Clement. "There were some comments such as, 'You shouldn't let anybody in who tests positive on a drug test.' Or 'Why don't you charge people who go into an ED a whole lot more money?'"

Ms. Clement says that a drastic increase in co-pays is probably unrealistic. "This whole notion of cost-sharing is not a very easy thing to administer. We have a very poor population, and one that is exempt from most cost-sharing requirements," she explains.

Other ideas might be worked on over the long term, but won't result in a budget cut for the short term. Still, both providers and the general public appreciated being asked their opinion.

"We wanted them to be engaged. One of the best things about this process was the educational value," says Ms. Clement.

Providers were given information on the budget status, what providers are paid, and what percentage of total Medicaid costs this comprises. They were given a target amount to come up with, such as a 10% reduction in nursing home payments.

"It's one thing to say, 'We need a 3% reduction,' but it's different when they actually saw all the information across the whole Medicaid program," says Ms. Clement. "They may have come expecting to sit and listen, but walked out the door with their mouths wide open because they were amazed at the depth of the problem."

New systems rolled out

Idaho Medicaid just implemented a brand new Medicaid Management Information System (MMIS). While the program expects to reap many benefits from the new system, the timing was difficult. The implementation occurred right after a three-week payment freeze for all providers at the end of the last fiscal year. Then at the start of the new fiscal year, the new MMIS system was used to process all the claims that were held. Understandably, providers were very anxious about possible glitches.

"They had to take loans out to get through the payment freeze. Obviously, there are challenges any time you implement a brand new system," says Ms. Clement. "Frankly, we are inundated with provider calls, saying the timing of the new MMIS implementation in this budget environment couldn't be worse." Some providers were paid only a portion of their overall payment due to system problems, which had to be corrected.

Idaho Medicaid also replaced its eligibility system in early 2010. "We've been so focused on developing these new systems that we haven't even had a chance to catch our breath in terms of the health information exchange work," says Ms. Clement. "We haven't done much work at all in terms of that."

A recent layoff of 12% of the workforce made the system implementations more difficult. For two fiscal years, the state managed to avoid layoffs with the use of furloughs, but as of FY 2010, this was no longer feasible. "Not only was our workforce impacted, but we had to reduce operating costs, which means we have to pay our contractors less. So, that was a struggle," says Ms. Clement.

Idaho Medicaid's new systems are transitioning from a project phase to an operational phase, explains Ms. Clement, during a time when resources are already tapped.

"A year from now, or maybe even nine months from now, we will be in a better position. We will have better systems with improved functionality. Changes can be made easier than with the old mainframe systems," says Ms. Clement. "But right now, it's a tough time."

All of the policy changes related to cost reductions that need to be implemented ideally wouldn't be done with a brand new system. Generally, says Ms. Clement, "You want to have a stable environment that you know is performing the functions accurately before you start throwing in a lot of changes. But we don't have that luxury."

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Idaho Medicaid preparing for 100,000 new eligibles

The single biggest challenge with health care reform is "the increased resources needed to implement this legislation," says **Leslie Clement**, administrator of the Department of Health and Welfare's Division of Medicaid. "Idaho is currently experiencing budget deficits. Projections do not indicate that this will change much in the near future."

There will also be significant restructuring needed to meet the requirement to provide seamless enrollment procedures between Medicaid, the Children's Health Insurance Program, and the health insurance "exchanges" to be set up by the state, which will allow individuals to shop for health insurance coverage.

About 100,000 new eligibles are expected to come onto the program when Medicaid is expanded in 2014. "We have a fairly high uninsured rate in the state, in the neighborhood of 15%," says Ms.

Clement. "We also have a lot of kids who are eligible, but aren't covered. So, we will get the 'woodwork' effect as well. We think that will be significant."

The updated drug rebate program in the health reform legislation, however, will not help Idaho Medicaid. "It was written to reduce federal government costs. It is going to hurt Idaho, because all our pharmacy costs are in a fee-for-service environment," says Ms. Clement. "We have estimated that we will lose $5 million in state supplemental rebates."

On the positive side, there may be opportunities for Idaho Medicaid to expand quality improvement initiatives. "We will look for opportunities to make the state plan amendment to add health homes, to further develop that effort," says Ms. Clement.

Ms. Clement notes that Idaho is one of the leading states in terms of a rebalanced long-term care system. "Our nursing home population, in terms of Medicaid residents, has been flat for six years or so," she says. "We have many high-need individuals that are being managed in the community, and our aged and disabled waiver has continued to grow." More than 8,000 individuals are currently in that program.

Many of the individuals assisted by the indigent program, operated out of state and county general funds, are expected to become part of the expanded Medicaid population.

"For Idaho hospitals who see a lot of uninsured, I think the health reform will provide them with paying patients. It will be a good thing to not have so many uninsured in this state," says Ms. Clement.

The overall impact of health care reform on Idaho Medicaid, however, says Ms. Clement, "is a challenging analysis to do, and it hasn't been done. I'm jealous of states that could do that kind of analysis, but we just don't have the funds."

Although in the initial years, funding of benefits will be covered exclusively with federal funds, an increase in human resources to process applications will be required to accommodate this large influx of individuals, notes Ms. Clement. Eligibility and other automated systems also will require modification, which will necessitate an increase in state spending.

Currently, analysts are looking at how much the expansion population will cost the Medicaid program, but there are also potential positive results that are as yet unknown. "What we don't yet see, is how bad debt, charity allowances, and uncompensated care that is provided throughout the state today will be reduced," says Ms. Clement. ■

Downturn is good time to evaluate LT care

While the Patient Protection and Affordable Care Act offers opportunities to enhance long-term care services in Medicaid, one obvious obstacle is fiscal.

For instance, the 1915(i) Home and Community-Based Services (HCBS) state plan option was revised to broaden the scope of covered services. States can now use it to serve the same population that meets both the functional and financial criteria of their existing HCBS waivers.

However, since the legislation requires statewide coverage and doesn't allow program enrollment ceilings, few states are likely to be able to afford this option.

"Most states are cutting programs in one way or another. They are either restricting services or lowering provider rates," says **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group that helps to develop and strengthen long-term care programs.

HCBS cuts are possible

When the enhanced federal medical assistance percentage (FMAP), recently extended through June 30, 2011, expires, however, the federal restrictions on eligibility reductions that were a condition of receiving this money also disappear. "That is a savings option that has been off the table. But if state problems persist for another year or two, you will probably see eligibility reduction as well," says Dr. Hendrickson.

"I don't see a lot of new money coming in, but what I do see is a smart continuation of current trends and efficient use of what is there," says Dr. Hendrickson.

On the state level, Dr. Hendrickson points to Pennsylvania's transition program as a successful model. As part of the program, housing coordinators were hired and local housing regional coordinating committees were set up for various state agencies.

Lack of housing has made transitioning residents out of nursing homes difficult in some programs. Now, efforts are being made to address this at the federal level.

"All of a sudden, you have the awareness that helping people leave nursing homes is in some part a housing issue," says Dr. Hendrickson. "There is more organization and planning going on in these upper department levels on how to make

the programs mesh a little easier."

For states with severe shortfalls, Dr. Hendrickson says that "budget deficits are simply so horrendous that everything gets put on the table. It is easy to cut HCBS, so that seems to get put on the table a little bit faster by the budget folks."

Nursing home and HCBS reimbursement rates have been cut or frozen in many states. For example, in New Jersey, nursing homes did not receive a cost of living increase in Medicaid reimbursement rates for FY 2011. "That's a $56 million dollar hit. That same pattern is happening in other states — Maryland, Massachusetts, Indiana," says Dr. Hendrickson.

The bottom line is that this is a time for Medicaid programs to operate as efficiently as possible. "Folks need to plan as carefully as they can, and try to ride through the lean years," says Dr. Hendrickson. "When the budget situations improve, as they inevitably will, you will cope with the unmet needs that stack up during the recession."

Dr. Hendrickson says that in the meantime, state Medicaid directors should do these things:

1. Build better data systems for long-term care.

"There is still a lot of room for building better data systems, studying your programs, and organizing what you do better," says Dr. Hendrickson. "There are states that don't have common assessments. They can't compare the characteristics and costs of people in nursing homes vs. those getting care in the community."

2. Analyze the cost-effectiveness of the Money Follows the Person programs and closing large state institutions.

"Money Follows the Person programs are now operating in 30 states. Just what are the savings of helping people move to lower-cost methods of care?" asks Dr. Hendrickson. "It's about time that both state and federal budget staff paid attention to this."

3. Consider the interrelationships between programs.

As a former senior budget analyst in a Medicaid program, Dr. Hendrickson says that in his opinion, budget analysts often fail to consider the interrelationships between users of programs.

"Budget analysts see lines on paper and see dollars attached to them, and just start cutting," he says. "The only intellectual tool they use is a scissor. Once you start cutting some of these programs, you're going to be increasing the number of people going to nursing homes."

The idea is to manage programs as a group, instead of viewing them as a separate series of line items or making across-the-board cuts. "Don't ignore the give and takes among the programs. All of this long-term care stuff is very interrelated," says Dr. Hendrickson. "If you think of programs in isolation, you're really missing the boat."

The fact is, says Dr. Hendrickson, people are moving between these programs continuously by the thousands. A data system is needed to link all the programs together, to shed light on the reasons for the movement, and the costs and characteristics of the people who are moving.

"In a time of no money, this is a good activity to do," says Dr. Hendrickson. "This is a great time to plan. Unless you become more efficient now, you will have larger and more complicated problems in the future." ■

States must do more to slow long-term care cost trends

Several initiatives designed to slow current cost trends in long-term care spending are highlighted in *Medicaid Long-term Care: The Ticking Time Bomb*, a report from the Washington, DC-based Deloitte Center for Health Solutions. These include "person-centered care," which provides the consumer with greater choice and alternatives, rebalancing to increase use of home and community-based services, and use of Medicare waivers for additional experimentation to improve care and manage cost.

Bob Campbell, vice chairman of Deloitte and head of the firm's state government practice, says that these are other potential avenues for states:

• improved targeting of primary and secondary risk factors and co-morbidities;

• increased home monitoring;

• improved evidentiary health analysis to understand expenditures and which services are cost-effective;

• ensuring continuity of case management and enhanced care management approaches.

"A number of states have implemented programs to help address the long-term care cost curve. There are promising examples addressed in the report," says Mr. Campbell. "However, given an aging population, the incidence of chronic disease, and health care reform's mandate for increased access to care, every state is going to need to do more on this front."

State Medicaid directors need better clinical data, incentive-based programs to reward case managers, and "increased sophistication in treating complex medical problems," says Mr. Campbell.

In many states, Medicaid agencies have delegated long-term care management to separate agencies responsible for their populations, but the Medicaid agency is still responsible and accountable to the Centers for Medicare & Medicaid Services due

to funding. "Medicaid directors and these other agency heads need to improve collaboration to control costs and increase quality," says Mr. Campbell.

Mr. Campbell says that currently, Medicaid programs are focusing on health care reform implementation, including health information technology, health information exchanges, and developing improved eligibility enrollment processes.

"While this focus is proper, it is clear state Medicaid directors will need to enhance their focus on a longer-term approach to care management in long-term care in order to address this issue," says Mr. Campbell.

Some quality initiatives for long-term care, at the state level, are emphasizing consistent staffing and retention. **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group that helps to develop and strengthen long-term care programs, says that Colorado's pay-for-performance program, which includes staffing-related measures, is a model that other states would benefit by looking at.

Under Colorado's program, nursing homes get additional reimbursement if they can show they have career ladders, offer tuition reimbursement for staff, promote from within, and involve certified nursing assistants in care planning.

"There is a heavy emphasis on retention of staff and consistent staff assignments," says Dr. Hendrickson. "That goes directly to the heart of the turnover problem in direct care workers, by stabilizing that turnover through better salaries and working conditions." ■

Medicaid's high-cost clients grow in importance

High-cost, high-needs clients are already a growing focus for many Medicaid programs. Evidence shows that a small fraction of Medicaid beneficiaries accounts for the lion's share of expenditures.

Now that states will be assimilating an estimated 16 to 20 million additional Medicaid beneficiaries, finding ways to more cost-effectively provide care to this population is even more critical.

"It is fair to say that this is on the radar screen of most states," says **Allison Hamblin**, director of complex populations for the Hamilton, NJ-based Center for Health Care Strategies (CHCS). "Given the economic climate we have been in now for several years, and not seeing the light at the end of the tunnel in the short term, states are extremely focused on how to most effectively martial increasingly limited resources."

The expansion will be entirely federally funded at the outset, but the enhanced federal match is not permanent. At some point in the near future, states will have to come up with additional resources to cover the expansion population.

Some states have already implemented innovative approaches to identifying their impactable populations more effectively. The goal, says Ms. Hamblin, is "to put people who could really benefit from care management into some type of system of care, instead of being in a totally unmanaged fee-for-service environment, which is generally the case for these high-cost populations." Here are some approaches, outlined in the CHCS April 2010 policy brief *Medicaid Best Buys: Critical Strategies to Focus on High-Need, High-Cost Beneficiaries*:

• Enhanced primary care case management (PCCM) programs

These programs, which provide more intensive care management for patients with complex needs, are in place in North Carolina, Oklahoma, Pennsylvania, Indiana, and Arkansas. "This is particularly effective when managed care is not a feasible or attractive option," says Ms. Hamblin.

• Physical and behavioral health integration

Many beneficiaries in the highest-cost segment of the Medicaid population have physical and behavioral health conditions. Ms. Hamblin says that leading examples of integration include Pennsylvania and Washington.

"They are doing great work to make change at the system level to support and facilitate information exchange and alignment of incentives across physical and behavioral health providers, to promote an integrated system of care," says Ms. Hamblin.

Ms. Hamblin says that this integration is "a program imperative right now. If you want to more effectively manage costs and improve the care of complex, high-cost populations, it has to be done with an eye toward integrating behavioral health and physical health systems."

This can be done with either a carve-in or carve-out system, she says, so long as the channels of communication are open and support coordination.

• Integrating care of dual eligibles

Currently, CHCS is working with seven states on the Transforming Care for Dual Eligibles initiative to design new programs to integrate care for individuals who are dually eligible for Medicaid and Medicare.

One option is the more traditional approach of integrating Medicaid and Medicare services through Medicare special needs plans, as New Mexico and Minnesota are

doing. An alternative option is a shared savings model.

"Vermont and Massachusetts are interested in a model where the state would serve as the integrated entity, and get Medicare payments directly for dual-eligibles," says Ms. Hamblin.

What really works?

"In terms of what we know through robust evidence documented through randomized controlled trials, the unfortunate reality is that it takes a long time," says Ms. Hamblin.

Evaluations are currently under way for CHCS' Rethinking Care Program, which uses state-led pilots to test new care management approaches for Medicaid's highest-need, highest-cost beneficiaries. All of the projects in that program have external evaluations.

"This will contribute to the evidence base of what we know works to control costs and improve outcomes," says Ms. Hamblin. "However, it will be a while before we have that data."

Through its extensive work with states, CHCS has identified a set of critical components essential to improve care management for high-need, high-cost populations. "Through these efforts, we have come to feel pretty confident about some of these critical elements," says Ms. Hamblin. Here are several:

• **The ability to exchange information**

Programs must make sure that those who are actually providing care have access to the full set of available information that could better inform the care that is being provided.

"Increasingly, there is a focus of hospital notification being provided real-time," says Ms. Hamblin. "That is one of the findings from some of the Medicare demonstrations that have informed our work to integrate care more effectively."

For instance, the physical health plan notifies the behavioral health plan in real time that one of their shared members has been hospitalized. Therefore, that member receives more timely outreach from both physical health and behavioral health providers, as appropriate.

• **Financial alignment**

"When attempting to integrate across entirely separate systems of care, alignment of financial incentives can be a powerful tool to encourage collaboration," says Ms. Hamblin. Whether you are integrating Medicaid and Medicare benefits or physical health and behavioral health, the idea is to remove the disincentives for collaboration.

• **Pharmacy management**

"Pharmacy data provide a near real-time and rich source of clinical information, particularly in the case of complex patients who receive care from multiple providers and systems," says Ms. Hamblin. The analysis and reporting of pharmacy data allows both prescribers and patients to be better informed of potential adverse drug interactions or to address adherence issues.

Consumer engagement is key

Partnering with health plans and other care management organizations to manage care has been occurring for some time in Medicaid programs. However, this is typically done only with children and their families. Adults with disabilities and those with multiple chronic conditions are typically not included, although these individuals constitute the bulk of the high-cost population.

"This segment has primarily remained in a fee-for-service system," says Ms. Hamblin. "It is easier for states to partner with health plans to serve children and their families. The provider networks are better understood. And for the most part, their health care needs are simpler."

Medicaid's highest-cost patients, on the other hand, have a diverse array of physical, behavioral, and psychosocial needs and require a far more sophisticated level of risk adjustment. "It can be challenging to set capitation rates for this population. That is one reason why moms and kids moved into managed care much earlier than the [Social Security Income] and [Aged/Blind/Disabled] populations," says Ms. Hamblin.

Psychosocial issues that go beyond traditional health care are as important for those populations, in many cases, as the underlying health issues. "We are still learning about what works," says Ms. Hamblin. "It is a multifaceted problem. The good news is, it's increasingly on the radar. We are learning more every day about more effective strategies to improve care for complex needs populations."

One trend is to try innovative ways to more effectively reach the patients who are identified for enhanced care management. "Some states are making incredible strides in that regard. Washington State, in particular, has developed some really novel strategies," says Ms. Hamblin.

One of the state's pilots achieved between a 50% and 70% enrollment rate in a care management program for a very complex population, which previously had an 18% enrollment rate. A few states are also piloting incentives to engage consumers more effectively. "A $20 grocery gift card goes a long way to someone being willing to have a conversation about having their needs met in a program like this," says Ms. Hamblin.

Motivational interviewing is a technique used by care managers that emphasizes the central role of consumer preferences in establish-

ing care management goals. A treatment plan is built around their own stated needs and priorities. "We are observing that effective consumer engagement is critical to the success of these programs," says Ms. Hamblin.

New opportunities

Ms. Hamblin notes that there are "a variety of new opportunities through health reform to support these efforts."

States are now allowed to do a state plan amendment to create coordinated health homes for members with multiple chronic conditions. It specifies beneficiaries with serious mental illness in particular, and individuals with one chronic condition and a risk for developing another.

"There is enhanced federal match available for two years for states that pursue this option. Planning grants are available to support the development of these models," says Ms. Hamblin.

A related provision involves community health teams. There is the possibility of grants to support state efforts to develop community-based, coordinated patient-centered care approaches for people with multiple comorbidities.

"The challenge is for states to take advantage of these opportunities in the midst of expanding coverage to a whole new population," says Ms. Hamblin. "It is a balancing act, but there are some incredible opportunities."

Contact Ms. Hamblin at (609) 528-8400 or ahamblin@chcs.org. ■

Community health centers expected to double

Increased funding for Community Health Centers included in the health care reform legislation is expected to nearly double the number of patients seen by the centers over the next five years to nearly 40 million.

Daniel R. Hawkins, senior vice president for public policy and research at the National Association of Community Health Centers in Washington, DC, notes that the legislation also will result in some 35 million people gaining either Medicaid or private insurance coverage.

"That could result in incredible health care delays, unless there is adequate health care availability," says Mr. Hawkins. "We think Congress realized this. That is why is they included money to expand health centers now, in advance of the coverage expansion."

Mr. Hawkins says that ultimately, this is a positive development. "I know that states don't necessarily see the Medicaid expansion as good news, but I think that they actually should," he says. "Having a much lower uninsured population means they are going to be in a much better position [to] respond more effectively to people. You won't have a whole bunch of folks left out, who go through back doors to get the care they need because they don't have coverage."

Currently, there are 8,000 health center sites in the United States, which Mr. Hawkins says is "well short of the number needed. We have thousands upon thousands of medically underserved communities. These are typically low-income communities, often inner-city, but also rural, with too few providers."

More primary care

Mr. Hawkins notes that there are some 60 million people across the country today who do not have a family doctor or regular source of primary and preventive health care.

"We all know that this is important as a foundation for health care," says Mr. Hawkins. "That is where health centers are most needed, where communities don't have enough of the right kind of care. Primary care is on the downswing and needs to be revitalized."

The health reform bill also gave a significant increase in funding to the National Service Corp Bill. This provides scholarships or loan repayment to medical and dental and nursing students, in return for practicing in underserved communities. "The beauty of the Service Corp is that it focuses on the two most important aspects of workforce reform," says Mr. Hawkins.

First is the need to revitalize primary care. "Every single assignee provides primary health care. This, we hope and trust, will be a great incentive to pursue a primary care career path," says Mr. Hawkins.

The second issue is the distribution of primary care practitioners. "They come out of school and don't go where we're over-doctored. They go to places where they are really needed," says Mr. Hawkins. "So, it addresses the maldistribution issue, both by discipline and by location."

Mr. Hawkins says that he is already seeing positive changes, such as the fact that more primary care residency slots were filled in 2010 than in the past 10 years.

"Things are starting to turn around already," says Mr. Hawkins. "The [Service] Corp and some other programs in the health reform bill are going to accelerate that positive shift."

Low rates for primary care, which discourage some medical students from choosing a primary care career path, will be addressed. "In the reform bill, you have two things.

Medicare is going to give a 10% bonus to those who work in underserved communities. Medicaid payment rates are going to be raised to the Medicare levels for primary care," says Mr. Hawkins. "That is going to be fully federally funded. With each of these changes, we are stepping on the accelerator a little bit more."

Medicaid will benefit

Mr. Hawkins says that Medicaid programs should see significant savings as a result of the expansion of community health centers, because underserved clients will have a place to go for appropriate care.

"Medicaid will benefit because of the incredible savings that health centers deliver by reducing inappropriate specialty care, diagnostic referrals, hospital admissions, and emergency room use," he says.

A June 2010 report from The George Washington University's School of Public Health and Health Services, *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, suggests that the expansion of health centers over the next 10 years could result in as much as a $300 billion savings. Of this amount, $90 billion will be federal Medicaid savings and $60 billion in state savings for Medicaid.

"The federal government will invest about $430 billion in the Medicaid part of reform, and state share will be about $25 billion," says Hawkins. "But they will get $60 billion back in the way of lowered costs, for both their currently enrolled and newly enrolled beneficiaries, just because of the work that health centers do."

Mr. Hawkins says, "The data shows pretty clearly that when people go to health centers, the total cost of their overall care is 23% lower than if they get their care elsewhere." Community health centers have strongly supported an expansion of Medicaid.

"With all of its difficulties and shortcomings, Medicaid is still the very best health coverage for low-income Americans," Mr. Hawkins says. "The biggest problem it faces is getting enough providers to serve that population."

Community health centers are the providers today to one out of every eight Medicaid beneficiaries in America. "And they would strongly desire to do more, working in collaboration with the Medicaid agencies," says Mr. Hawkins.

For this reason, Mr. Hawkins says that it is in the best interest of Medicaid directors to reach out to health centers through state primary care associations.

"They know where the care delivery points are most desperately needed in the state," he says. "States, health centers, and the state primary care associations that represent them can and should work together to find and enroll these newly eligible people, and get them into a system of care that will provide the greatest value possible."

Contact Mr. Hawkins at (202) 296-0131 or dhawkins@nachc.org. ■

Health care reform bill focuses on readmissions

The Patient Protection and Affordable Care Act (H.R. 3590) puts considerable focus on reducing hospital readmissions. Here are some excerpts and key provisions from the bill on this subject:

• By 2012, the Secretary of the Department of Health and Human Services (HHS) will develop reporting requirements for use by health plans to improve health outcomes and "implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional."

• Under Part II on consumer choices and insurance competition through health benefit exchanges (section 3590-55), there is a section on rewarding quality through market-based incentives. One of the strategies mentioned involves "the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional."

• Under section 2703, which discusses a state option to provide medical homes for enrollees with chronic conditions, there is a monitoring provision that describes "a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and (2) a proposal for use of health information technology in providing medical home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

• In section 3023, which features the national pilot program on payment bundling, there are quality measures established that include the following: "(i) Functional status improvement; (ii) Reducing rates of avoid-

able hospital readmissions; (iii) Rates of discharge to the community; (iv) Rates of admission to an emergency room after a hospitalization; (v) Incidence of health care-acquired infections; (vi) Efficiency measures; (vii) Measures of patient-centeredness of care; (viii) Measures of patient perception of care; (ix) Other measures, including measures of patient outcomes, determined appropriate by the secretary."

- The independence-at-home demonstration program (section 3024) makes a requirement of testing the model for accountability with these quality measures: "(A) reducing preventable hospitalizations; (B) preventing hospital readmissions; (C) reducing emergency room visits; (D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness; (E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests; (F) reducing the cost of health care services covered under this title; and (G) achieving beneficiary and family caregiver satisfaction." ■

Check CMS website for readmission comparisons

Hospitals will need to get used to the idea of reporting their 30-day readmission results as the new health care reform bill expands on this initiative of the Centers for Medicare & Medicaid Services (CMS).

In addition to published reports of hospital 30-day mortality rates, CMS features 30-day readmissions measures for patients who were originally admitted to the hospital for heart attack, heart failure, and pneumonia.

The information is available to consumers at www.hospitalcompare.hhs.gov.

CMS uses a model that is based on claims data and has been validated by clinical data models to assess hospital readmissions and mortality rates. The model takes into account medical care received during the year prior to each patient's hospital admission, as well as the number of admissions at each hospital.

For the period of July 2005, to June 2008, CMS reports that 19.9% of patients nationally with acute myocardial infarction were readmitted within 30 days of hospital discharge; for heart failure patients, the national data show a 24.5% 30-day readmission rate, and for pneumonia, the 30-day readmission rate was 18.2%. ■

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