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Interest in Medicaid medical homes is surging, despite budget challenges

The challenges of budget shortfalls aside, interest in medical homes continues to grow as evidence of their effectiveness accumulates and state Medicaid programs seek to manage costs over the long term.

A medical home is "an enhanced model of primary care in which care teams attend to the multifaceted needs of patients and provide whole person comprehensive and coordinated patient-centered care," according to the Portland, ME-based National Academy for State Health Policy's (NASHP) June 2009 report, "Building Medical Homes in State Medicaid and CHIP Programs."

"There is a lot of state interest in this at the moment," says **Neva Kaye**, NASHP's senior program director. "I have definitely seen an increased interest in medical home initiatives over the last two years."

Budget shortfalls mean that some planned medical home initiatives are being delayed, however, since an initial investment is required. "This really varies by state and how bad their situation is and how far along in development the infrastructure is. Or the budget may be in such bad shape that they have no way of making an investment," she explains.

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In This Issue

Colorado's Medicaid program expands to cover 100,000 insured

The Colorado Health Care Affordability Act has just been signed into law, which will provide coverage to more than 100,000 uninsured Coloradans without any cost to taxpayers, phased in over three years.

Fiscal Fitness: How States Cope

State general funds will not need to be leveraged to draw down additional federal funds to provide coverage. Instead, by assessing a provider fee on hospitals, Colorado will generate about $600 million a year to provide coverage to the uninsured and receive $600 million in federal matching funds. The combined $1.2 billion will cover more than 100,000 currently uninsured Coloradans through its Medicaid and Child Health Plan Plus programs.

"Colorado has a strong commitment to expanding public health insurance. The Colorado Health Care Affordability legislation allows for us to follow through on that commitment. There is also a recognition that now the hard work needs to happen to get federal approval," says **Sandeep Wadhwa**, MD, Medicaid director and chief medical officer with the Colorado

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Medical homes

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"But I have certainly not seen any lessening of interest, even if they have to delay what they are doing."

Jeff Schiff, MD, medical director of Minnesota Health Care Programs and division director at the Minnesota Department of Human Services, says budget shortfalls haven't adversely affected the state's planned medical home initiative.

"We have had a terrible budget year with a big deficit. But because there has been enough momentum on this, we haven't been derailed," he reports. "The legislature and our administration have supported us continuing with this project. Everyone believes it is worthwhile to go forward."

The medical home program is expected to be budget-neutral. "We can do that if we run this tightly and carefully enough," says Dr. Schiff. "Some studies say that if you alter the ratio of physicians even slightly from specialist toward primary care, you find a significant improvement in quality and decrease in cost in the broader population. But I don't think the models are developed enough at this point to say we will save or lose a certain amount."

Oklahoma's Medicaid director, **Lynn Mitchell**, MD, says over the long term, she expects their medical home program will help members access health care for preventive measures and see their provider earlier during an illness.

"We anticipate earlier care will mean care delivered in the more appropriate place, and that would lead to a decrease in emergency room usage and inpatient days," she reports. "Decreasing the frequency and severity of illness is a huge enhancement to quality of life for the Oklahomans we serve. It's too early to tell if any of that will take place, but that's what we're hoping for."

Dr. Mitchell also hopes the medical home program will serve as a good model for other payers to promote good health care for their members. "We are anxious to obtain some experience in the model, which we anticipate will result in more satisfied providers and members, as well as enhanced care and wellness," she says. "It makes sense to deliver health care in this integrated fashion."

'Complicated' patients targeted

As principal investigator for the State Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Beneficiaries, Ms. Kaye surveyed state officials and found 31 states had implemented at least one medical home initiative since 2006 that included Medicaid and CHIP beneficiaries.

"This isn't a new issue, particularly for Medicaid, but some states are slightly ahead of the curve," he reports.

Medical home programs varied, ranging from programs focusing on smaller populations, such as adults with chronic conditions, to programs that ultimately aim to change the delivery system for everyone in the state, such as those under way in Minnesota, Oregon, and Iowa.

Most of the programs started by covering a particular subset of the population, such as adults with complex needs or children. For example, Colorado's Medicaid agency set up a program for all children covered by Medicaid in the state. Currently, 88,000 Medicaid and 62,000 Child Health Plan Plus children are enrolled in a medical home, and 97 practices representing 310 physicians are designated as medical homes.

Some of the medical home programs were explicit in indicating they planned to eventually expand to all state residents, but of those, several intended to start with the Medicaid and CHIP programs.

Both Minnesota and Rhode Island are developing medical home initiatives for people with complex needs, and individuals must have multiple chronic conditions to qualify. "Their intent is that once they get everything worked out for the subpopulation, they will have a process to build on so they can expand it to capture more populations in the state," says Ms. Kaye. "To me, that makes perfect sense, because before going that broad with a program, you want a chance to tweak it and adjust it. You might want to do things differently."

This summer, Minnesota will start enrolling individuals with five or more chronic diseases in its Medicaid fee-for-service programs.

"Some of us believe that if you can do this for complicated patients, then you can do it for less complicated ones," says Dr. Schiff. "Half of the spending we have in fee-for-service Medicaid goes to one-eighth of the patients, who have the most complex needs. So, we felt like we should have the most positive impact on their health and in our costs by targeting that group. When we did our analysis of who was to be included, we identified 27,000 folks who fell into that category."

As of July 2010, the program will expand to all clients in state health care programs, state employees, and privately insured individuals. Dr. Schiff says he looks at this as "two waves hitting the shore."

Rhode Island, on the other hand, is focusing on all adults with chronic care needs who are served by certain primary care practices, without looking at a particular subset. "So, even looking at the states that targeted it, the way they targeted it varied quite a bit," says Ms. Kaye.

According to **Chris Traylor**, Texas' state Medicaid director, a medical home initiative will be rolled out within the next 12 months. "The initiative will test multiple medical home models to determine if health outcomes improve for children enrolled in Medicaid," he says. "Our agency will be consulting with a panel of experts to develop minimum standards for the models and evaluation criteria for the project."

Colorado's program started with children covered by Medicaid, with the intent to expand it to their CHIP program. One advantage of starting with Medicaid children involves the Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit (EPSDT).

"EPSDT is set up as a benefit that's designed to not only offer good primary care, but also to support outreach enrollment and care coordination," says Ms. Kaye. "It's a benefit that is well designed for supporting medical homes within Medicaid, and it's a benefit that is only available to children."

By starting with a subset of patients with specific health care needs, you can see results more quickly. "I don't want to call them low-hanging fruit, because they are really not. Some of them don't have access to primary care at all, so moving them to a fully functioning medical home is not always the easiest thing to do," says Ms. Kaye. "But where you will see a potentially big benefit is in preventing some of those unnecessary ER visits and hospitalizations."

Ultimately, however, some of the biggest cost-saving benefits will come from primary care on the preventive side. "To establish a medical home for someone with diabetes is a good thing. There is a lot of benefit to be gained," says Ms. Kaye. "But if you can make sure somebody has access to a medical home, which can prevent the diabetes from happening, that has even greater potential. Vermont has done a lot with their Blueprint for Health program to emphasize the preventative side. I think that is where states ultimately have a vision of going."

Oklahoma's medical home program was implemented in January 2009. "While it's still early on, indications are that our members are very pleased," says Dr. Mitchell. "We've also gotten a lot of comments back from providers who say they have found this a comfortable and satisfying way to interact with our members."

Providers receive compensation through a payment structure that better reflects the value of what they do for patients. "This model improves our health care system by coordinating and integrating care and focusing on quality," says Dr. Mitchell. "Everyone wants to be cared for in an environment that embraces those tenets, and providers want to practice in that environment."

Initially, there was concern that Oklahoma's providers might choose not to renew their SoonerCare contracts, but the vast majority did. "We also attracted quite a few new providers who were anxious to practice within a patient-centered medical home model," says Dr. Mitchell. "And when we calculated our first incentive payments under Sooner Excel, 87% of our providers who served as medical homes qualified for the incentives."

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States take these five actions to advance medical homes

Here are five ways that states are working to advance their medical home programs, according to research conducted by the State Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program Beneficiaries:

1. Forming key partnerships.

In a new development, states are partnering with private purchasers, consumers, and providers. "States are interested in building on partnerships. Everybody can get farther if you are headed in the same direction," says **Neva Kaye**, the project's principal investigator and senior program director for the Portland, ME-based National Academy for State Health Policy. "There is a great opportunity there for partnership. The newer initiatives are very much designed with the input of the people that are going to function within it."

2. Defining a high-functioning medical home.

"This is really important, because not every practice is a high-functioning medical home," says Ms. Kaye. "If you are going to tie payment to performance, you need to define how practices are going to function and what they are going to achieve. You need to make sure those you are paying and supporting really are doing what patients need."

While Minnesota and Oklahoma developed their own standards, many others have adopted the National Committee for Quality Assurance's Physician Practice Connections—Patient-Centered Medical Home model. "I view the existence of that and other tools as fostering state interest at this point. You can really tell which practices are high-performing medical homes, and you need that piece," says Ms. Kaye.

Jeff Schiff, MD, medical director of Minnesota Health Care Programs and division director at the Minnesota Department of Human Services, says "what a medical home really offers for our clients and the agency is an opportunity for improved care, so patients with chronic illnesses can have their care coordinated and improved."

In 2004, the state received a grant for children with special health needs. "We developed a very robust medical home model through that, which ended up serving 25 practices and about 7,000 kids," says Dr. Schiff. "From that model, we got momentum for a lot of the things that have appeared in our criteria. We had that experience to build on, which gave us an advantage."

Since Minnesota's providers started out with different levels of understanding about what a medical home is, a lot of time was spent over the past two years coming up with a common definition.

"That groundwork has taken some time, but I think it has been very beneficial," says Dr. Schiff. Minnesota's criteria emphasize patient and family-centered care and quality improvement at the practice level, as opposed to implementation of electronic health records (EHRs).

"In contrast to some of the other states, we have de-emphasized EHRs. It's not that we don't want everyone to have EHRs. As medical homes develop, they will probably need EHRs to do the job well and be cost-effective. But we see it as a tool, not as a criteria for being a medical home," says Dr. Schiff.

A paper verification process for medical homes is currently used, but going forward, the department of health will have a verification process that includes some site visits and technical support. "Our program is a little different than some other states," says Dr. Schiff. "We are working on the program in collaboration with the department of public health, and we are developing a model that can be used both by the public sector and private sector."

3. Developing a methodology for reimbursement to support the medical home.

Ms. Kaye says states seem to be falling into two major categories for how they are going to reimburse providers for being a high-performing medical home. The first group structures payment like a primary care case management (PCCM) program, with a fee-for-service payment for all the care that the practice directly provides, and also a per-member, per-month fee.

"In the old PCCM programs, those fees were often two or three dollars a month, but some of these programs are getting into fees of $40 or $50 a month. So, it's a quite significant payment to recognize significant administrative costs, in terms of care coordination and outreach, for performing as a medical home," says Ms. Kaye.

However, states also are tying specific requirements to payments, to create an incentive to do things that support a high-functioning medical home. For instance, Rhode Island will pay more to a practice with a nurse on staff to perform care coordination.

"North Carolina is an excellent example of that, and Oklahoma has shifted to that as well," says Ms. Kaye. "In both instances, additional payments are provided. Alabama is sharing some savings with participating providers. So, there is often an element of a payment that is tied to performance."

The second category that states

are falling into is payment of enhanced fees, which arises in part from the desire to use existing billing and claims procedures. For example, when a primary care provider performs a Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit on one of its medical home patients, it receives an enhanced payment of $36 over the regular screening fee.

"The idea is they are trying to create an incentive to not just recognize the administrative costs of being a medical home, but also for the provider to get the kid in the door. Those well-child evaluation visits are such a key piece of serving as a medical home," says Ms. Kaye. "So, they want to be sure the payment also incents that."

Minnesota also is using enhanced payments for very complex patients, which can amount to hundreds of dollars each year depending on the complexity of the patient's disease burden. "The idea is to create the incentive for an ongoing relationship," says Ms. Kaye. "Also, by using an enhanced payment, the regular billing procedures can be used, so it fits with the way the practices regularly bill. It makes it easier for the provider, because they don't have to do special billing things."

Minnesota already has established its payment methodology for its 2007 Provider Directed Care Coordination legislation, with a per-member, per-month fee averaging $50 paid to providers who care for patients with complex illnesses in its fee-for-service population. Currently, a payment methodology is being developed for the program's expansion to a much broader population. Minnesota passed legislation in 2008 requiring all its health plans to offer a medical home to patients with a chronic disease and to pay in a method that is consistent with the methodology developed by the Department of Human Services. A stratified pay structure is required, based on the patient's complexity.

"Rather than developing this method in secret, we are in the process of developing it collaboratively with our health plans," says Dr. Schiff. "We are being transparent with our health plans, so they can actually see what we are doing."

Enhanced payments for Minnesota's medical home patients can be billed by providers no more frequently than every six months. "Our legislature set out that the average cost would be about $50 a month to do the care coordination for these folks, so we set up three separate rates that average $50 a month," says Dr. Schiff. "We worked with the provider community, and we believe that the financial incentive for the practice is significant enough for them to provide this level of service."

Dr. Schiff says, "What we have always said is that we want real care coordination and real medical homes set up, and we expect real results. And we understand that it takes some capital to develop a system and also to run it."

4. Giving resources to support providers in becoming high-functioning medical homes.

"Change is hard, particularly if you are in a busy practice without a lot of time to spend," says Ms. Kaye. "Practices need to change the way they deliver care and to integrate being a medical home into their standard business."

For this reason, providing support for care coordination is important. In addition to this, some states are giving providers information about their performance, patient needs, and utilization.

Pennsylvania does this by offering providers access to health information technology and practice coaches, while Minnesota plans to hold learning collaboratives for physicians and practice teams. "In order to change the culture of primary care practices, we needed to create a social network to have that happen," says Dr. Schiff. "And as part of our patient-centeredness focus, we expect patients to be on the learning teams." New Hampshire has contracted with a local university to do a gap analysis, so practices seeking to become medical homes can identify where they will potentially fall short in meeting the criteria.

To be a high-performing medical home, care coordination clearly needs to happen within the practice. "That is one of the hallmarks of a medical home. But there are also other aspects of care coordination and outreach that can support the practices of a medical home," says Ms. Kaye. "For example, it's unrealistic to expect somebody in a medical practice to know all the community resources that can help an identified need. But a true medical home should be able to meet that identified need." For unique or very involved cases, it's important for the practice to have somewhere else to turn to.

5. Measuring results.

States are advancing medical homes because they want to achieve cost savings through better-quality care. However, proof that goal is being achieved may be difficult to come by.

"This is where I think that states are struggling the most," says Ms. Kaye. The first step is to identify measures on how the practice delivers care. For instance, do they have an electronic medical record or a nurse case manager on staff?

"But ultimately, what you really want to know is whether you are having the intended effect," she says. "Were hospitalizations avoided? Were unnecessary ED visits avoided? Those are the things you would ultimately

expect to change."

If you are evaluating appropriate asthma care, for example, you'll want to see the practice billing for certain services. Also, you want to use measures that can change relatively quickly. "You can't wait five years to show results," says Ms. Kaye.

Ideally, you'll want to use measures that have been validated and accepted nationally, so when a measure changes for the better, indicating that better quality care has been provided, the measure itself is not questioned.

In addition to hospitalizations and ED visits, the other thing states are measuring is the patient experience. "I use that term instead of 'patient satisfaction' deliberately," says Ms. Kaye. "Of course, they want patients to be satisfied. But they also want to know if the experience was what it should have been, in terms of appropriate care."

Dr. Schiff says Minnesota's primary goal is to be sure there is a real improvement in how care is delivered. This means more utilization of preventive services, less utilization of hospitalizations and EDs, and better patient engagement and decision making.

"We expect patients and families to feel much more aware of and engaged in their health and their health care planning. We have a big list of outcomes we are looking for," says Dr. Schiff. ■

North Carolina's medical home model saves $154 million

Medicaid clients with a longer history with the same doctor are more likely to be screened for curable cancers, according to a study of North Carolina Medicaid recipients published in the *Archives of Internal Medicine*. Researchers evaluated the medical records of nearly 2,000 state Medicaid recipients ages 50 and older. About half had received screening tests for colorectal, breast, and cervical cancers. The researchers also discovered that patients who had been seeing the same practitioner for more than five years were twice as likely to be screened as those who had been with a practitioner less than two years.

The study's findings gave additional evidence of the benefits of the Community Care of North Carolina (CCNC) initiative, which has enrolled more than 970,000 Medicaid recipients into a "medical home."

A recent actuarial study estimated CCNC saved $154 million in fiscal year 2007. Other research has indicated the effectiveness of CCNC for Medicaid patients with asthma, diabetes, and other chronic ailments.

"We weren't necessarily surprised by the finding that patients with long-term, established relationships with a primary care provider were more likely to have received recommended preventive services," says **C. Annette DuBard**, MD, MPH, the study's lead author and associate medical director of Quality Evaluation and Health Outcomes at the North Carolina Department of Health and Human Services' Division of Medical Assistance.

Many prior studies have shown that people with access to primary care are more likely to receive recommended care. However, the study's findings also suggest that access to care, in and of itself, isn't necessarily enough.

"Even though all of the patients in our study had full health care coverage for cancer screening under Medicaid and had visited a primary care doctor, a large percentage was not screened appropriately," reports Dr. DuBard. "Patients with longer-standing, continual relationships with their primary care provider were far more likely to be screened. This provides further evidence for the medical home model."

North Carolina has invested in primary care for its Medicaid recipients through enhanced management fees and support of locally driven quality improvement efforts and care coordination. "Many states, especially those operating in a primarily fee-for-service environment, have looked to North Carolina as a model for assuring that Medicaid recipients have access to a stronger primary care infrastructure," says Dr. DuBard.

Dr. DuBard adds that "as more and more evidence emerges that this approach can not only improve quality but help reduce overall health care costs, we can expect to see increasing emphasis on the medical home model nationwide."

Program's four components

CCNC adopted four essential program components, all designed to strengthen the ability of the primary care provider to manage patient care and improve patient outcomes. These four components are:

—Formation of community networks. "The primary care providers were encouraged to work together with other community providers in community networks to cooperatively plan for meeting the health care needs of recipients, particularly those with chronic conditions," says **Denise Levis Hewson**, RN, BSN, MSPH, CCNC's director of clinical programs and quality improvement.

—Population management tools. These provide the physicians and other network partners with the tools needed to improve care.

Providers are given evidence-based programs and protocols for disease management, pharmacy management, care management, and practice-based improvements.

—Case management and clinical support. These provide the support and coordination needed by physicians to care for complex chronic care patients who see many providers across an array of delivery settings.

—Data and feedback. Opportunities for improvement are pointed out in the areas of quality, utilization, cost, and care processes by collecting, analyzing, and regularly reporting performance metrics back to physicians and networks.

"These provide physicians with relevant information on how their patients are faring," says Ms. Hewson. "The community-based approach is very important. Having local physicians leading the efforts in their community has helped us achieve success."

As a result of its ability to improve the quality of care while containing costs and saving state dollars, CCNC is being looked upon as a vehicle for new initiatives in the state. Currently, the initiative covers all 100 counties through 14 regional networks. These manage the care of more than 970,000 Medicaid enrollees with about 1,250 medical homes and more than 3,200 primary care providers.

This provides the state with a launching pad for new initiatives, such as a contract with the Centers for Medicare & Medicaid Services to improve management of dual- eligibles and share in the savings. "One reason that states are hesitant to manage this population is that most of the savings occur on the Medicare side," explains Ms. Hewson. "We are also potentially developing a high-risk OB initiative."

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Fiscal Fitness

(Continued from cover)

Department of Health Care Policy and Financing. "I am sure there will be even more excitement when we are able to reduce the percentage of uninsured people and give people more options for coverage."

Dr. Wadhwa says he thinks the fact that the expansion didn't require a draw on the state general funds "moved us more into a philosophical discussion rather than an economic discussion. There was more discussion around 'What's the sustainability of this?' or 'Should we be drawing so much federal money?' But it wasn't controversial in that we weren't spending state general fund money."

The first expansion will bring children and pregnant women up to 250% of the federal poverty level (FPL) from 205%, and will bring caregivers up to 100% of FPL. "These expansions represent a win-win. Clients will receive coverage and comprehensive health care services, and providers will have a payment source for services that were previously uncompensated," he explains.

Dr. Wadhwa notes that while many states have expanded to similar rates of coverage, very few have used a provider fee to finance that expansion. "We can do the expansions up to 250% by state plan amendments," he says. "But the expansion for childless adults and buy-in program for people with disabilities require[s] waivers. This waiver process is one where we will really learn from other states."

Provider rates cut only 2%

According to Dr. Wadhwa, Medicaid wasn't planning to cut any optional services or eligibility categories even before the stimulus package. However, a 4% rate cut was being talked about for Medicaid providers. With the stimulus dollars, the state was able to keep up with expanding enrollment and also reduce the provider rate cut to 2%.

From an access standpoint, primary care and dental services are Colorado Medicaid's biggest areas of concern. "Having said that, we are also hearing from a lot of our providers that their practices are slowing down on their commercial side. As people have higher deductibles, they are not going to the doctor; so Medicaid becomes a better payer," says Dr. Wadhwa. "Our rate structure is still roughly at 90% of Medicare's, but that is a whole lot better than zero if your practice is having open slots."

Recently, Medicaid has seen some modest increases in provider enrollment. In October 2008, 70% of family physicians participated, and this number increased to 76% as of June 2009.

Despite feeling the impact of the recession, the state wanted to preserve the gains it made in primary care access, and the 4% rate cut was resulting in push-back from the provider community. "Certainly, states have had to make a lot more severe cuts than that. But the 4% was playing out as a 'free day for Medicaid,' as it came out to a little less than 1/20 of a work month," says Dr. Wadhwa. "We were sensing that we were pushing the envelope."

First, Dr. Wadhwa says, "We asked and received flexibility for how we accomplished the 2% reduction. We went to our providers asking for recommendations on how to save money on avoidable utilization as offsets to a rate cut. We had a fascinating and productive dialogue."

As a result, Medicaid's dentists,

primary care physicians, and direct care providers, including personal care workers and certified nurse assistants, got 0% rate cuts. All other providers got a 2% rate cut.

"What we came up with were some targeted volume reductions," says Dr. Wadhwa. "For example, we had a conversation with doctors about positron emission tomography [PET] scans. We had never put any rules or guidance in effect about these before. So, here was an area where doctors in the state agreed we could develop some prior authorization rules." Nonemergency CT scans and magnetic resonance imaging scans also were targeted.

"In collaboration with the doctors, we got ideas and buy-in by providers to take ownership to tackle areas where we felt like there were opportunities to safely reduce volume," says Dr. Wadhwa.

Likewise, feedback was obtained from the dental community, which identified some services as possibilities for prior authorizations to offset rate reductions.

"We also have a broader initiative around ERs and readmission rates. If we can pull that off, then I think we may be able to come off the 2% rate reduction for the other providers or mitigate the impact of potential future budget shortfalls," says Dr. Wadhwa. "These initiatives are still being defined."

No cuts in services

Medicaid's goal is to continue trying to find areas with avoidable utilization. However, a recent budget put a damper on those activities at least temporarily, with the distressing news that the state has a shortfall of $354 million for the upcoming fiscal year. "We are very anxious to work with the governor's office and the legislature to see what share of the shortfall the Medicaid program will have to bear," says Dr. Wadhwa. "From a state financing point of view, the rumors of economic recovery are still a little early."

Enrollment began climbing in January 2008 and has increased 12% over the past 12 months, with 60,000 additional clients in April 2009 than the previous year. Due to the stimulus funds, Medicaid was able to meet that caseload without cutting any optional services and benefits.

"We never proposed any cuts in services, but we certainly stopped considering expanding our services," says Dr. Wadhwa. "We had a whole agenda of new things we wanted to do. We had a plan to expand services for our adults and created a dental benefit that wasn't emergency only. That side of the equation got wiped out. We'll need to wait until we can find some financing to make that request. There is no ability to do that now."

As for medical home initiatives, these are "one of our central pieces of cost-saving and a way to improve health outcomes," says Dr. Wadhwa. "We will be getting a first year report that will give us a sense of how the programs are doing. In the interim, we are continuing to expand those programs. We've got a preliminary sense they are giving us good results."

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Medicaid may become platform for broader health care reform

How many of the country's uninsured should be covered through public programs and how many through private insurance? This is a topic of much debate regarding health reform legislation, with some policy-makers arguing that Medicaid should be expanded to cover more low-income and high-need people.

"A lot of the plans that are being considered do build on the Medicaid program as a base for coverage expansions," says **Robin Rudowitz**, a principal policy analyst for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured in Washington, DC, and former Medicaid director in the Office of Legislation at the Centers for Medicare & Medicaid Services (CMS). Ms. Rudowitz is an author of the May 2009 report, *Medicaid as a Platform for Broader Health Reform: Supporting High-Need and Low-Income Populations.*

Medicaid serving 60 million

Medicaid already serves 60 million people, providing affordable and comprehensive coverage for a low-income, high-need population. "And when you look at who is uninsured, two-thirds are low-income, and many do have significant health needs," says Ms. Rudowitz.

She notes that two leading proposals involve expanding Medicaid for all adults up to 115% and 150% of the FPL. Some states already have used Medicaid as a base for expanding coverage to childless adults who are not currently eligible for Medicaid.

"Many states have been taking action to try to address the uninsured population, but that has been somewhat halted by what is happening with the recession and also potentially because of the discussions on federal health care reform," says Ms. Rudowitz. "Certainly, states are struggling right now, in an extremely challenging fiscal environment. The recession has led to a major decline in revenue at the same time as there are major caseload

increases and more uninsured. So, states have immediate concerns on their budget side."

Another consideration is the varying impact that federal floors in terms of eligibility levels will have across the states. "Individual states are concerned about the floors and how the financing would be divided between the federal government and the states," says Ms. Rudowitz. "And those concerns are particularly heightened due to the recession. There is variation in their experience with the recession, but all states are feeling the impact."

Improvements are possible

Nationally, a lot of attention is being paid to the reforms made in Massachusetts, which are built heavily on the Medicaid program. However, Ms. Rudowitz notes that Massachusetts was "in a different starting place" than many states, because its health reform efforts already had expanded Medicaid.

Overall, Medicaid is considered to be a low-cost program, especially when compared to the cost of private insurance. "There is lots of research that shows that Medicaid provides access comparable to private insurance, especially for primary preventive health," says Ms. Rudowitz.

Medicaid has public support

Medicaid also has broad public support, and the public clearly favors using Medicaid as an option to expand coverage. In a 2007 Kaiser survey on children's health coverage for low-income families, 95% of respondents said they thought Medicaid and CHIP were good programs, and over 90% of parents said they would enroll their children in CHIP. "What we are hearing in some focus groups is that because of the recession, individuals who have never needed public assistance are losing coverage and coming to seek assistance for the first time through Medicaid," adds Ms. Rudowitz.

However, there are few options for single adults. "For children, there has been a pretty good safety net. But the recession has heightened the awareness of the gap in safety coverage," says Ms. Rudowitz. "There are certainly ways to strengthen Medicaid to make it a stronger platform, such as making eligibility based on income and eliminating categorical requirements. And while there has been a lot done to simplify the application process, there is more that can be done."

Providers cite admin burdens

When providers are asked why they are not participating in Medicaid, they typically cite low reimbursement and administrative burdens. "These can potentially be addressed, although of course, on the provider side there are larger issues," says Ms. Rudowitz. "With dental care in particular, there are access issues that go far beyond Medicaid because of the lack of providers."

Another possibility is the chance to reform Medicaid's payment policy. "If an expansion of Medicaid occurs, it would be an opportunity to look at the split and the share of the financing between states and the federal government," says Ms. Rudowitz.

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Enrollments in Medicaid-focused health plans continue to grow

Enrollments in Medicaid-focused health plans have risen by 14.2% over the past year, according to *Medicaid-focused Health Plans Continue Growing Amid Overall Decline in Medicaid Managed Care Enrollment*, a fact sheet released by the Association for Community Affiliated Plans (ACAP) in Washington, DC, based on recent data from the Centers for Medicare & Medicaid Services.

Medicaid-focused health plans now cover more than 11 million people, which comprise 53% of the Medicaid-eligible individuals enrolled in full-risk managed care. Medicaid-focused health plans provide services in 32 of the 50 states to enrollees in Medicaid, Children's Health Insurance Program, and other public insurance programs for low-income individuals.

"Enrollment in Medicaid-focused health plans continues to grow because of the value the plans provide to state purchasers," says **Deborah Kilstein**, ACAP's director of quality management and operational support. "Through investments in outreach, care management and other supportive services, Medicaid-focused health plans, such as the public plans in New York, have demonstrated their ability to have a positive, sustained impact on the quality of care."

Moreover, Ms. Kilstein says Medicaid-focused health plans are able to provide this comprehensive and high-quality care in a cost-effective manner that results in long-term state savings.

"For this reason, with health reform, we believe that Medicaid-focused health plans will and should continue to be a critical component of the platform for expanding coverage to other lower-income and vulnerable populations," says Ms. Kilstein.

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Medicaid rates haven't kept up with Medicare's

Medicaid physician fees haven't kept up with Medicare fees, and this could be contributing to problems with accessing care, according to a recent study on *Trends in Medicaid Physician Fees*, 2003-2008.

The study, published in *Health Affairs*, was conducted by researchers at the Urban Institute in partnership with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured in Washington, DC, and the California HealthCare Foundation in Oakland.

Medicaid historically has reimbursed physicians under fee-for-service at levels below what Medicare and private health insurers would pay for the same services. The study finds that Medicaid fees increased by 15% from 2003 to 2008, but fell in real terms because the gains did not keep pace with inflation. Medicaid fees did grow faster than Medicare fees during that period, however, rising from 69% of Medicare in 2003 to 72% by 2008. Increases were greatest in Medicaid fees for primary care and obstetrical services.

Some payments increasing

Despite the impact of the recession, some states have managed to avoid cutting Medicaid provider reimbursement rates, and in some cases, even increased rates. "We did not cut but in fact increased some physician payments. We are launching an all-payer, patient-centered medical home pilot in 20 physician practices statewide," reports **Trish Riley**, director of the Governor's Office of Health Policy and Finance in Augusta, ME. "We were able to provide funds in the budget for Medicaid to participate in that pilot, despite cutting $500 million from the budget and for the first time in memory having a budget that is lower than the last biennium's."

Maine also is preparing to convert hospital payments to DRG/APC next year. In addition, funding was provided for a new "Doctors for Maine's Future" scholarship program that will support a new medical school collaborative involving physicians doing rotations in Maine's rural hospitals to encourage doctors to practice in the state.

North Dakota gives increases

North Dakota Medicaid has given rate increases to hospitals, physicians, chiropractors, ambulance services, and dentists, who also will receive a 6% inflationary increase in the second year of the biennium. All Medicaid providers that did not receive a specific rate increase will receive a 6% inflationary increase each year of the biennium.

The state also passed a bill allowing nurse practitioners to serve as primary care providers for Medicaid clients. "We are anticipating implementation of that later this calendar year. It is expected that this will assist with assuring Medicaid clients have access to the services and referrals needed," says **Maggie Anderson**, director of the Division of Medical Services for North Dakota's Department of Human Services.

Barriers to access ID'd

An April 2009 study, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare*, found that overall, Medi-Cal fees were 83% of the Medicaid national average in 2008. This report by the Urban Institute, funded by the California HealthCare Foundation, compares 2008 Medi-Cal physician fees for selected procedures with fees paid by other states' Medicaid programs and by Medicare.

California's fees rank 47th overall among states when adjusted for geographic differences in the cost of providing medical care. Among the 10 largest state Medicaid programs, California ranks ninth. Also, considerable variation exists in Medi-Cal fees across procedures in relation to national averages, with relative fees ranging from less than 70% to more than 140% of the national average.

From 2003 to 2008, Medi-Cal physician fees grew, on average, by only 2%. This compares to 15% growth in average Medicaid fees nationwide and 21% general inflation during this period. Medi-Cal reimbursement for most dental care procedures also falls short of those

for Medicaid nationally.

According to **Toby Douglas**, chief deputy director of the California Department of Health Care Services and the state's Medi-Cal director, "the financial environment in the state is very difficult and Medi-Cal, as the second largest state-funded program, must be part of the budget solution."

Mr. Douglas says there are three ways in which Medi-Cal costs can be reduced: Eligibility rollbacks, reimbursement rate reductions, and benefits cuts. "Recent budgets have touched upon all of these areas, but eligibility reductions are no longer permitted under new federal requirements," he says.

The state's governor recently sent a letter to the president seeking program flexibilities to slow the rate of growth within Medi-Cal and allow the state to manage Medi-Cal within the framework of available resources. "Discussions with the president's staff are ongoing," says Mr. Douglas. "If the effort is successful, flexibilities could come in Medi-Cal rates, benefits, and cost-efficiency rewards."

A component of the governor's 2007 health care reform proposal was across-the-board reimbursement rate increases. "Unfortunately, the proposal failed," says Mr. Douglas. "The governor continues to look at ways to ensure that the state is able to provide health care for our most vulnerable populations."

Grants improved access

A May 2009 report, *Specialty Care in the Safety Net: Efforts to Expand Timely Access*, conducted by the San Anselmo, CA-based Pacific Health Consulting Group, examined the barriers to access in specialty services for uninsured and Medi-Cal populations in California, particularly orthopedics, gastroenterology, neurology, and dermatology. The researchers evaluated the impact of grants funded in 2007 by Kaiser Permanente Community Benefit Programs and the California HealthCare Foundation to regional provider coalitions to develop strategies to improve access.

"There is a very delicate balance between Medi-Cal funding and the lack of funding for care for the uninsured. In the current environment, when you have large numbers of newly uninsured coupled with potential major changes in the MediCal program, I think we have to assume that we might not move as far as we might have in a better economic situation."

— Bobbie Wunsch
Pacific Health Consulting Group, San Anselmo, CA

According to the report, more than half of the regional coalitions plan to implement one or more of five types of improvement activities. These include development and implementation of referral and clinical care guidelines, training for primary care providers to expand their scope of practice to incorporate specialty care activities, expanded specialist networks, web-based referral or consult systems, and referral coordination improvements.

According to **Bobbie Wunsch** of the Pacific Health Consulting Group, the program "gave rise to a lot of technical assistance, grant funding and peer learning along the area of specialty access. We wanted to look at what and how [these] had been impacted by the work that the foundation had done."

Ms. Wunsch says the research identified some promising trends, such as expanded specialty services, use of web-based referrals, and use of telemedicine to provider specialty services, both in urban and rural areas. For example, a subspecialist might be available by telemedicine to several community health centers, so patients don't have to travel long distances to see that provider.

Ms. Wunsch says she anticipates that state budget cuts to Medi-Cal could result in increasing problems with access, however, particularly in the areas of optional services, psychology, podiatry, and optometry. "Any cuts that come from the state budget on counties with public hospitals will have an indirect effect on the Medi-Cal population. If the counties then require funding cuts from the public hospitals, there is no question that access will be impacted. It's hard to know how deep the cuts will be in Medi-Cal." The impact of any cuts will probably be exacerbated in the counties that provide health care services to large numbers of Medi-Cal patients, she adds.

Ms. Wunsch says the theory is that the funding that was provided will act as venture capital to accelerate the development of collaborative programs at the community level. "There is a very delicate balance between Medi-Cal funding and the lack of funding for care for the uninsured," says Ms. Wunsch. "In the current environment, when you have large numbers of newly uninsured coupled with potential major changes in the MediCal program, I think we have to assume that we might not move as far as we might have in a better economic situation. When you consider that, coupled with the fact that even more people are delaying care, the picture isn't as rosy as it might have been."

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Chronically ill who smoke need added help to quit

Individuals with serious illnesses, including cancer, heart disease, and chronic obstructive pulmonary disease, make up a disproportionately high segment of current smokers and are also among the most addicted to tobacco use. Despite their strong addiction, more than one-third of these individuals are likely to give up smoking and remain smoke-free for at least six months if they receive a combination of smoking cessation medications and are allowed to continue taking these medications for a longer period of time, researchers at the University of Medicine and Dentistry of New Jersey (UMDNJ) report.

In their study, the researchers randomly assigned 127 smokers with predefined medical conditions to one of two groups. The first group received nicotine patches for a standard 10-week treatment period. The second group received a combination of nicotine patches, nicotine inhalers, and bupropion, an antidepressant medication commonly prescribed for treating tobacco dependence. After 26 weeks, 35% of those who received the combination therapy had quit smoking, compared to just 19% of those who received the nicotine patch alone. The results of this study appear in the April 7 edition of *Annals of Internal Medicine.*

"Common sense would tell you to quit smoking if you have a serious disease, but more than half of smokers who are newly diagnosed with cancer continue to smoke," said study author **Michael Steinberg**, MD, MPH, assistant professor of general medicine at the of the University of Medicine and Dentistry of New Jersey (UMDNJ)-Robert Wood Johnson Medical School in New Brunswick and medical director of the Tobacco Dependence Program at the UMDNJ-School of Public Health in New Brunswick. "Our research illustrates how terribly addictive tobacco is, but that addiction can be overcome if treated appropriately."

Current product labeling discourages combining nicotine patches with other forms of nicotine replacement and strictly limits the recommended length of time these products should be used. At the same time, treatment for tobacco dependence is not usually reimbursed well by insurance companies. Both are mistakes, Dr. Steinberg contends.

"People with serious illnesses who smoke will live longer and have a better quality of life if they receive aggressive treatment for their tobacco dependence," Steinberg said. "Insurance companies will bristle at paying for six months of nicotine therapy, but will turn around and allow benefits for 50 years of prescription statin medications to control cholesterol. Tobacco dependence should be considered like any other chronic illness and, with the right amount of therapy, people can remain tobacco-free for good." ■