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In This Issue

Many unknowns mean long-term fiscal uncertainty for Medicaid

During Utah's last legislative session, a decision was made to commit a minimal amount of dollars to Medicaid expansion, since it was unknown whether the enrollment growth surge the state was seeing would continue.

"And what's happened since that point in time has been a *tremendous* growth in the program," says **Michael Hales**, the state's Medicaid director. "We were approaching the budget with a 'wait-and-see' approach. Now, we're going to have to see whether we can get some ongoing funds in really large dollar amounts to keep the program going as it currently is."

Despite signs that the economy is recovering, the number of Medicaid enrollees continues to rise in many states, in some cases to unprecedented levels. In 2009, Medicaid spending grew 7.9%, well above the projected growth at the start of the year, according to the September 2009 Kaiser Commission on Medicaid and the Uninsured (KCMU) report, "The Crunch Continues: An Update on Medicaid Spending, Coverage and Policy in the Midst of a Recession—Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010." Three-quarters of Medicaid

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Vermont seeks to maintain its 'generous' Medicaid program

Although Vermont Medicaid, which offers some of the most generous benefits of any state, proposed several cuts to its program to make the program sustainable in the long run, the legislature didn't approve any of these. As a result, Medicaid was forced to make provider cuts to get through the short term. To maintain the program over the long term, however, cost-containment programs and increased use of health information technology (HIT) will be key.

Fiscal Fitness: How States Cope

Susan W. Besio, PhD, director of the Office of Vermont Health Access and Vermont Health Care Reform, says her biggest challenges of the moment are twofold: maintaining programs in the current fiscal environment, and also understanding the implications of federal health care reform.

"Because things keep changing, we don't really know what is going to happen ultimately. It's hard to know what we can and can't do moving forward, and what we should be doing to be smart for our programs, our beneficiaries, and our budget," she says.

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Fiscal uncertainty

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directors surveyed said there was a 50% likelihood that their budgeted amount for 2010 was not going to be sufficient.

"Our income tax and capital gains revenue has gone down. We've taken a hit in every segment of the economy," says **Michael P. Starkowski**, commissioner of Connecticut's Department of Social Services. "The question now is, how quickly can we rebound? And how can we do it with as little damage as possible?"

For FY 2010, states are already starting to make some programmatic restrictions, particularly in the area of benefits and provider payment rates. "Should states run into Medicaid budget shortfalls, they will be back at the table looking to trim costs more," says **Robin Rudowitz**, one of the authors of the KCMU report. Ms. Rudowitz is a principal policy analyst for the Washington, DC-based KCMU and former Medicaid director in the Office of Legislation at the Centers for Medicare & Medicaid Services (CMS).

Lillian Koller, director of Hawaii's Department of Human Services, says the state's revenue has fallen by about $3 billion since last year, mainly due to a sudden and substantial drop in tourism activity caused by the global economic recession. "Hawaii is required by law to enact a balanced budget, meaning state officials must make some very difficult decisions during this troubled economic period," she reports.

The number of recipients of Hawaii's Medicaid programs has increased by about 10% over the past year, adding about 1,500 to 1,700 new recipients per month. "Government officials are working hard to maintain benefits in the face of declining state revenues and increasing Medicaid caseloads," says Ms. Koller.

Larry Iversen, director of South Dakota's Division of Medical Services, says the state's Medicaid program has seen an increase of more than 500 new enrollees each month since November. "This is the largest growth pattern the state has seen in Medicaid enrollment," he says. "Higher enrollment increases overall program costs, and South Dakota does not have the funding to keep up. Potential changes in FMAP are also a challenge for our state, as South Dakota's personal income has remained more stable than other states."

South Dakota has not made cuts to the Medicaid program. "However, before the stimulus, we would have had to consider cutting some optional services," says Mr. Iversen. "At this time, we do not know if South Dakota will have to look at cuts when the stimulus funding runs out. We are looking for state funds to fill the hole."

Tremendous growth continues

When surveyed in the summer of 2008, state Medicaid directors projected a growth of 3.6% for 2009 on average. The KCMU survey revealed that in fact, enrollment grew 5.4%. "We knew that enrollment and spending were going up," says Ms. Rudowitz. "But this provided numbers and showed how much higher enrollment and spending were from what states had budgeted for fiscal year 2009."

Mr. Hales says Utah Medicaid's biggest challenge at the moment is "tremendous growth in the program during a very difficult budget status for the state. We have seen, for our state fiscal year 2009 that ended in June, a 19% increase in enrollees in the program. That, in a climate where state revenues are down, is

putting tremendous pressure on funding for the program."

While Utah Medicaid had about 165,000 monthly enrollees in June 2008, that number had climbed to 195,000 by June 2009. "We are at an all-time high in terms of absolute number of enrollees. We just crossed the 200,000 enrollee mark in September 2009 for the first time ever," says Mr. Hales. "Even going back and looking at our percentage growth rates during the budget down cycles of 2002 through 2004, we only saw a 10% or 11% annual growth rate."

Utah Medicaid saw only a 3% growth rate in FY 2008, with some months going up and others down, but enrollment has gone up steadily since December 2007. In 2009, the program has seen a 19% growth rate, "For the first three months of the FY 2010, we saw a 17% growth rate. So it may be slowing down a little, but I wouldn't say a lot," says Mr. Hales.

Connecticut's projected deficit of about $8 billion in its two-year budget resulted in the longest legislative session for the passage of its appropriations act in the state's history. "And a lot of the reason for that deficit is the burgeoning costs of health care in our state systems, especially in our Medicaid program and what we call our State Administered General Assistance (SAGA) program," says Mr. Starkowski. "The numbers have been increasing exponentially every month."

In the state's Husky-A program, its basic Medicaid managed care program covering the non-fee-for-service and non-ABD populations, enrollees increased by about 20,000 people in the past year, going from 330,000 to over 350,000. "That is a significant increase. That really is a strain when the state is having a difficult time trying to make ends meet," says Mr. Starkowski.

Enrollment in the state's CHIP program has stayed pretty constant for the past year, in the 15,000- to 16,000-person range. However, its new Charter Oak program for uninsured adults is now serving more than 11,000 newly covered people. In SAGA, the increase was from 34,000 to 42,000.

"Our numbers have been going up out of sight, like the numbers in other states," says Mr. Starkowski. "People are losing their jobs and their health benefits. And if you have no income coming in, you will be eligible for Medicaid if you have kids. So, we are trying to keep the system we have in place. We are trying to make sure we have sufficient providers, who are all crying out for rate increases in order to meet their additional expenses. So, it's a real challenge, just trying to keep the program viable."

Concern over the 'cliff'

Before the financial help came through from the federal government through the American Recovery and Reinvestment Act (ARRA), Utah Medicaid was looking at a number of eligibility groups for possible reductions. "I don't know what those eventual decisions would have been, because we didn't have to make them, given the timing of when the stimulus package was approved," says Mr. Hales.

"Our big concern, going into our next appropriation process, is that a lot of the money in our budget is one-time money, whether that is coming from the stimulus package or just appropriations for our program right now," says Mr. Hales. "We will have to see what our state revenue situation looks like. But we could be back to looking at a full range of reduction options again, possibly including eligibility."

According to the KCMU survey, state Medicaid directors are expecting a 6.6% enrollment growth on average for 2010. "So, there is still a feeling that enrollment is growing. There is an expectation that even if the recession officially 'ends,' the impact on state Medicaid programs will linger, for at least a year or two," says Ms. Rudowitz. "States are already now starting to think about their budgets for 2011. And midyear through state FY 2011 is when the ARRA funds for Medicaid will expire. States are not expecting their economies to be in full recovery by then. So, I think there is quite a bit of concern about that cliff."

As for what was done with the ARRA funds, 38 states said they avoided or reduced the level of planned provider rate cuts, and 36 said they avoided cutting some benefits. "So, certainly, they might have to come back and look at those again," says Ms. Rudowitz.

Ms. Koller says the budget picture for Hawaii Medicaid is unclear for both the current and upcoming fiscal years, primarily because contract negotiations are still ongoing with some of the public sector employee unions. "Uncertainties about future revenues and expenses make it difficult to conduct long-range planning at this point," she adds.

Ms. Rudowitz notes that since this recession is coming pretty quickly after the last economic downturn in 2001 to 2004, there was a short recovery period before states were again faced with another downturn. "States implemented a lot of cost-containment during the last downturn. So, if there were any easy places to go to get efficiencies or reduce program spending, then it's already been done," she says.

Will planned expansions survive?

Due to the ARRA funding requirement that states maintain eligibility levels, "states can't go backwards

right now," says Ms. Rudowitz.

A number of states still are moving forward with expanding coverage for children, as plans were in the works, and they were able to move forward once CHIP reauthorization occurred. "But there is a combination of uncertainty with what's happening with health care reform and the economic situation. That is causing states to put other expansion plans on hold," says Ms. Rudowitz.

Utah's 1115 waiver, called the Primary Care Network Program, pays a limited benefit package for an expansion population, including a premium subsidy program. A waiver amendment that's before CMS right now would allow the current subsidy program, which only subsidizes employer-sponsored insurance, to be a subsidy for privately purchased health plans, COBRA insurance plans, and the state's insurance high-risk pool.

"We recognize that a lot of people are losing their employer-sponsored insurance, so we would like the subsidy available in different circumstances than just employer-sponsored insurance," says Mr. Hales. "We are still moving ahead with that, because the budget is already there for our primary care network or the premium subsidy. If we expand our subsidy, we will just limit enrollment in our primary care network."

Mr. Starkowski attributes soaring Medicaid enrollment in his state largely to job losses in the economic downturn, noting that the state has significant wealth but also a significant number of low-income families and individuals. "For the past 10 or 12 years, we have done things to make sure we have not only appropriate programs to serve the indigent, but we also have instituted a number of programs for working people," he says. "We've been doing a lot of progressive things in Connecticut. We do try to take a chance and a risk and do different things for our population."

He points to the state's CHIP program, which provides coverage regardless of income. "If you hit 300% of the FPL, you pay the negotiated rates with the managed care program, but your child gets good, unsubsidized coverage for about $195 a month. We kept with that same mantra when Gov. [M. Jodi] Rell initiated the Charter Oak program, which covers single adults 19 through 64 who aren't eligible for other programs. If you're eligible for Charter Oak and you hit 300% of FPL, you pay the unsubsidized, negotiated premium, currently $259 a month," says Mr. Starkowski.

"We recognize that even working people have a difficult time paying for coverage, even if it's offered by an employer," says Mr. Starkowski. "That's why we put in the Charter Oak program. And it's worked out well for thousands of previously uninsured individuals, especially for a brand-new program. It's a reasonable program that provides affordable access to health care."

This year, the state added the option of a primary care case management (PCCM) program to its Husky program. "So, we not only have three managed care entities, but also two pilots going on in the state with PCCM. And we will be expanding that to more areas of the state," says Mr. Starkowski.

In addition, Connecticut has appropriated funds to put its Medicaid fee-for-service population under care management. "It could be anything from an ASO [Administrative Services Organization] to a partially capitated arrangement to a managed care arrangement. But we are trying to provide some care management, instead of just a free-standing population without any assignment to a primary care physician or anybody working on disease management," says Mr. Starkowski.

The budget also authorized funding for Special Needs Plans (SNPs) for dual-eligibles, with two entities in the state currently participating. "We've always been kind of reluctant, because I personally think the jury is out on whether the state saves money or not," says Mr. Starkowski. "These were originally put in place to save Medicare money, and we don't know if those states that have joined together with SNPs for Medicaid and Medicare have really saved any state money or enhanced the quality of life for individuals. But we'll find that out."

Provider rates take a hit

Although Utah Medicaid didn't have to face the unappealing prospect of reducing eligibility categories, fairly large reductions were made to provider reimbursement.

"That's where most of our reductions have come," says Mr. Hales.

The strategy was to roll back the equivalent of about three years worth of inflationary appropriations that had been given to providers. In addition, some provider groups had some targeted reductions. Inpatient hospitals were one of the groups targeted for bigger reductions, because of a perception that their reimbursement was comparatively favorable to other providers in the Medicaid program.

While pediatric dentists received a large increase in October 2007, they took a 25% reduction in their reimbursement for FY 2009. Hospitals took a 15% reduction, pharmacy took a 10% reduction, and most other providers were given a reduction of 5% or less.

"In terms of access, we haven't seen a lot of dentists disenroll from the program yet. We've seen about a 4% drop in our dentist enrollment since it went into effect, which is not a huge amount," says Mr. Hales.

"But we *have* seen them become very politically active in terms of trying to explain the consequences of what's happened. We've received a lot of letters saying they are going to give us a couple of months to restore the cuts, going into our next legislative session."

Primary care physicians were given only minimal reductions of about 1%. "Our physician rates were already pretty low, and we feel like they are the backbone of the program," explains Mr. Hales. "In the past, they have taken cuts or not gotten as much new funding as other providers." Adult dental services have been funded on and off over the past five years, "so that one's usually a casualty of down times in the economy," says Mr. Hales. "It was offered as a benefit in 2009, but we didn't get additional funding to keep it going in 2010. So, it was not technically a budget cut, because it was funded only for one year."

Eyeglass coverage, hearing aids, chiropractic services, and speech therapy were cut. "We did eliminate a number of optional services, although we didn't really have very many in the state of Utah to begin with," says Mr. Hales. Two other optional services, occupational and physical therapy, were cut temporarily in 2009, but these were restored for FY 2010 with one-time funding. All of the cuts in optional services saved Medicaid only about $550,000, however, compared with $25 million in provider reductions.

Hawaii's Medicaid program scaled back adult dental benefits on Aug. 1, 2009, to the level they were prior to December 2006, when only emergency procedures such as tooth extractions were covered. "Medicaid began covering preventive and restorative dental services in December 2006, but those costs became unsustainable due to the current recession," says Ms. Koller. "Needy parents can still receive free preventive and restorative dental services, however, as part of Hawaii's welfare-to-work programs. Also, all children in our Medicaid programs continue to receive full dental benefits."

Rates increased in FY '08 & '09

For FY 2008 and 2009, Connecticut gave significant increases to many of its Medicaid providers, including hospitals, primary care physicians, and pediatricians. "A lot of those rate increases were actually designated by the legislature and governor to try to increase participation of the providers needed to take care of our population," says Mr. Starkowski. "And those rate increases actually worked out well, because we did have a significant increase in the number of providers."

This year, however, few — if any — of the state's Medicaid providers will receive rate increases. "That's pretty much across the board. Whether it's a nursing home, a specialist, or a primary care physician, their rates have all been frozen," says Mr. Starkowski. "We tried everything possible to keep the provider rates where they were."

However, a number of initiatives reduced provider rates to pharmacies. These include reducing the maximum allowable cost for generics, decreasing the dispensing fee paid to pharmacies, and increasing requirements for prior authorizations for pharmaceuticals.

In addition, a copay of $15 maximum per month for pharmacy was added for dual-eligibles, the annual enrollment fee was increased for the ConnPACE prescription drug program for elderly and disabled individuals who aren't eligible for Medicaid, and enrollment was limited in a Medicare Part D plan to a benchmark plan. Individuals used to be allowed to go into any plan with the state paying the monthly Part D premium.

"So, there are places where we increased the client's financial participation. We recognized that if we reduced the rates to our providers, we would be in jeopardy of not having access for our clients," Mr. Starkowski says.

Since Connecticut's budget was just passed, whether these changes will have a negative impact on access is not yet known. "When I talk to nursing homes and provider groups, every one of the groups is disappointed. All of them felt that their particular group should have gotten an increase. But I think that they all understand what is going on with Medicaid," says Mr. Starkowski. "The problem wasn't one that could be solved by just raising income taxes in order to provide everybody with the increase they were looking for."

The increased FMAP percentage, says Mr. Starkowski, "really helped the revenue position in the state of Connecticut. Our FMAP is normally 50%, and we went to 60.19% with the ARRA bump, and recently to 61.59% with another ARRA adjustment, based on our unemployment rate. When you consider we are spending $4 billion on an annual basis, an increase of 10 percentage points means a lot."

Elimination of adult dental services was considered, but a softer approach was taken by adding the requirement for prior authorization for some dental services, in order to try to limit abuse, overuse of services, and encourage the use of less costly procedures.

There also was a major adjustment in the budget to reduce the capitation rates paid to managed care programs that serve 350,000 family members under the Husky program, the state's Medicaid managed care program, amounting to a 6% cut on that program.

"But after all of these cuts, we still have a Medicaid line item that is the single largest expenditure in the state of Connecticut, and I think that's the way it is in a number of states," says Mr. Starkowski. "Right now, our agency has about $4.9 billion in our appropriation, and about $4 billion goes to Medicaid services. We have our waiver programs, home care, fee-for-service programs, and the list goes on and on."

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Fiscal Fitness

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Minimal fiscal analysis is being done, since this is complex work that is difficult to do without concrete details. "However, we *are* doing a lot of policy analysis of the different versions on a daily basis, saying, 'This would be good for us, this wouldn't be, this would be OK," says Dr. Besio. "We are also working with our congressional delegation to get them information about current versions of the bills and analyzing the policy implications."

'Maintenance of effort' is concern

When it comes to health care reform, Dr. Besio says "because every state Medicaid program is very, very different, including a state's readiness to operate an exchange or cover Medicaid beneficiaries up to 133%, it's hard to give a global response."

Dr. Besio says she is particularly concerned about "maintenance of effort" requirements. "The language seems to be pretty consistent across all the different versions. I really think this ties all states' hands, in terms of our ability to manage within our current economic strengths."

The basic intent is to require state Medicaid programs to keep whatever eligibility methods, standards, and procedures they have in place. "That language is in the ARRA [American Recovery and Reinvestment Act] funding, which goes until December 2010. So, we can't change any of that anyway, until then. But the language in the federal health care reform bills would cause us to have to keep that maintenance of eligibility until 2013 or 2014, depending on the version," says Dr. Besio.

The dilemma, therefore, is that the ARRA funding will be discontinued in December 2010, while states are not expected to be economically stable for another year or two. "We would be required to keep our existing program intact, but without the help," says Dr. Besio. "So, the only place we can go as state Medicaid programs to deal with that cliff is to cut provider rates, which creates an access issue. You can't change the benefits within the program. You can require higher copays or cost-sharing. But you can't increase premiums if people pay premiums, because that's considered an eligibility procedure."

Vermont Medicaid's only options to balance its budget may be increasing cost-sharing or cutting services such as dental or chiropractic. With the state facing significant deficits in projected revenue, this may be an untenable situation. "If you are just doing both of these things alone, you would have do them so drastically that it would not be feasible," says Dr. Besio. "This is especially true for high-coverage states, frankly. For those of us covering a lot of people at much higher income levels and offering very generous, robust benefits, we're kind of stuck with that. So, maintenance of effort is a major dilemma."

Another fiscal challenge for Vermont Medicaid came last year, when the legislature didn't approve the elimination of chiropractic services as an optional benefit. Instead, they agreed to reduce it to certain codes without eliminating it altogether. Next, Medicaid proposed reducing dental benefits for adults, but again, this wasn't approved. A third proposal to eliminate Medicare Part D wraparound coverage, which is funded totally by state general funds, was not approved.

"Those are some examples of cutting state-funded only programs or benefits that we were proposing to help make our program sustainable, but the legislature chose not to do," says Dr. Besio. "On the one hand, we were hopeful that the legislature would understand the significant financial situation we are going to be in for the next couple of years. The earlier we can make changes to our program to accommodate that, the better. But on the other hand, no one really wants to cut benefits. So, it's a very difficult dilemma."

In the end, provider rates were cut by 2%, and the way pharmacy is reimbursed was changed significantly. However, certain evaluation & management codes primarily used for primary care were exempted from the provider rate decrease. "We tried to protect primary care physicians in that rate reduction. We also exempted some other provider categories that have either cost-based reimbursement or a federal requirement that they get an annual inflationatory increase each year," says Dr. Besio. "The stimulus funds were used basically

to balance our budget, so we didn't have to implement significantly more cuts."

VT committed to reform

Vermont remains committed to comprehensive health reform since passing its 2006 landmark health reform legislation. "We continue to see our enrollment grow in our state-sponsored programs and our new programs offered through our health care reform legislation," says Dr. Besio. "And that would make sense, because they are low-cost, high-coverage programs. And they are based, for the most part, on people being at 300% or below the FPL. So, as people are losing their jobs, more are becoming eligible."

A survey done by Vermont Medicaid last fall showed that uninsured rates went from 9.8% to 7.6%, since the new initiatives were launched in November 2007. "So, in a year, we reduced our uninsured rate by 2.2%. That doesn't sound like a lot, but when you get to that low of an uninsured rate, it's really hard to entice those last few people," says Dr. Besio.

Major statewide initiative

A new Medicare demonstration project will allow Medicare to join Medicaid and private insurers in state-based efforts to improve the way health care is delivered. "This demonstration project's specific design is still to be defined, and states have to apply to be a demonstration project state once the guidance is published," says Dr. Besio.

While Vermont will have to apply to be a site, the demonstration is largely designed based on the multi-insurer payment and delivery system reform embodied in Vermont's Blueprint for Health integrated medical home and community health team pilot.

The state's Blueprint for Health program is a major statewide initiative that Dr. Besio says she hopes will have an impact "in the mid- to long-term range."

Blueprint for Health is part of a statewide approach to health, wellness, and disease prevention, with Integrated Health System pilots currently under way in three communities with a combined population of 60,000 patients. These pilots include Patient Centered Medical Homes (PCMH) supported by Community Health Teams (CHTs), and an HIT infrastructure that supports guideline-based care, population reporting, and health information exchange.

Fiscal incentives are aligned with health care goals. With the exception of Medicare, all major insurers are participating in financial reform that includes two major components. First, primary care practices receive an enhanced per person per month (PPPM) payment based on the quality of care they provide. "The payment is based on the practices' official NCQA PCMH score and is in addition to their normal payments," says Dr. Besio. "Every six months, practices are rescored against the NCQA's nationally recognized quality indicators."

This approach provides an incentive for ongoing quality improvement, as payment is adjusted up or down based on five-point incremental changes in the score. Payments can range from $1.20 to $2.39 PPPM, providing a substantive incentive for thorough outpatient care.

In addition, insurers share the costs for the CHTs. Each of the three pilots has a CHT that includes five full-time equivalents (FTEs) at a cost of $350,000 and is intended to provide care support for a general population of 20,000 patients.

"The staffing mix for the CHT is designed in each community based on local need," says Dr. Besio. "The team members form a nucleus that works closely to coordinate with other personnel and services in the community, establishing a functional CHT that is much larger than the five FTEs. The Blueprint model is designed to be sustainable, scalable, and adaptable for all practice sizes, and from rural to urban settings."

ROI projected at $36M

The financial return on investment projected over five years for the Integrated Pilots is more than $36 million. "If Vermont is approved as a demonstration site, we will have the capacity and leverage to broaden the Blueprint's current reach, since right now we are using state funds to support Medicare's portion of the program," says Dr. Besio.

In addition, during the past legislative session, the agency was given the statewide authority for HIT planning. "So, statewide HIT planning and implementation is very closely coordinated with Medicaid, because it's embedded within the same organization," says Dr. Besio. "We are really excited. We think that we can take advantage of the incentives very quickly. It's really going to jump-start our efforts."

An analysis is being done currently to determine the best way to do that, while waiting for further clarification on the "meaningful use" requirement from CMS.

"I think anything that is going to help bring down errors, decrease the need for unnecessary tests and exams, decrease the amount of paperwork, and make individuals more aware of the totality of their medical records, all of that is going to be really helpful in the long run," says Dr. Besio.

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Is 'doing business differently' enough to help cash flow?

There is no question that states are working hard to get better value for their Medicaid dollar by implementing various quality initiatives with an eye toward reducing long-term costs. "They are constantly trying to work on program integrity issues. But the problem with some of the quality things, in particular, is that it's hard to see overnight savings," says **Robin Rudowitz**, a principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured in Washington, DC. "States are still implementing those things. But when states are facing cash flow problems, that's not going to help them with that."

Michael P. Starkowski, commissioner of Connecticut's Department of Social Services, reports that the agency recently lost 250 people as a result of a retirement program for state agencies. This means that fewer people are there to take the state's exponentially increasing number of Medicaid applications.

"Everybody is stepping up to the plate to do more with less," says Mr. Starkowski. "Having been here many years, I've been through this at least two other times. At the end of the day, it's a wake-up call for doing business differently. Now you have to; there is no choice. In times like this, there are real opportunities to change the system. And that's what we are trying to do."

Here are some of the ways Medicaid programs are saving dollars:

• Doing a better job of detecting fraud.

Connecticut has developed a data warehouse, funded partially through enhanced CMS funding, which enables real-time "data mining" of claims submitted to the department. These are analyzed to check for any unusual expenditures, aberrations in trends, or substantial increases. "We will work with providers to see if we can weed out fraud, or at least be a sentinel out there to discourage fraud," says Mr. Starkowski.

• Moving ahead with health information technology (HIT).

Utah Medicaid is looking closely at the potential fiscal impact of HIT incentives for providers. "I think it will help some provider groups more than others," says director **Michael Hales**. "The biggest thing we are looking at is the requirement that the physician practice's client base has to be 30% Medicaid in order to qualify for the funds. We probably aren't going to have quite as many qualify for that as we'd like. But in terms of infrastructure, we are doing a number of things."

To facilitate the sharing of data, Utah Medicaid is drawing on the strength of the state's regional health information exchange, called UHIN. An all-payers database is being built with a clinical health information exchange. "Those initiatives were under way well before the stimulus package came out. Now we are just looking at how the incentives can help to support that infrastructure," says Mr. Hales.

Mr. Starkowski explains that Connecticut Medicaid already has taken advantage of some of the earlier transformation grants that were available from the federal government. "We are now starting to roll out our e-prescribing program. We will be rolling out our EMR and e-health records programs in the next six to eight months," he says. "We are working closely with our department of public health, as they are the entity designated to accept the dollars for enhancements. We've got our hands in everything to do with HIT."

A group of stakeholders has been convened to work out how the federal incentives for providers will be distributed. "It's difficult for a small provider to bear not only the expense of getting the equipment in, but also to get the staff trained. And we've been pretty proactive in that arena. That is why we moved right into e-prescribing right when the dollars became available," says Mr. Starkowski.

• Changing what constitutes "medical necessity."

To make care more cost-effective, Connecticut Medicaid received authorization to change its definition of "medical necessity" to be consistent with the definition used by Medicare. "If there happens to be a new procedure approved yesterday requiring a $15,000 payment and there is a proven procedure used for years that will get the same results and costs $3,000, we now have the ability to say, 'Even though the doctor requested Procedure Y, we will approve Procedure X.' This provides the same quality of services at a lower cost," Mr. Starkowski explains.

• Implementing a return prescription drug program.

Connecticut Medicaid has implemented a prescription drug return program with skilled nursing facilities to redispense available medications if a patient leaves the facility or is deceased. "On an annual basis, we probably save about a million-and-a-half dollars, and we are doing a push to save even more," says Mr. Starkowski.

• Expanding the Preferred Drug List (PDL).

Connecticut's Department of Social Services' pharmaceutical and therapeutics committee recently expanded its PDL. The PDL originally covered only the Medicaid fee-for-service program covering elderly and disabled individuals. It is now

being expanded to the Husky A, (Medicaid for families and children), Husky B, (the state's SCHIP program) and the State Administered General Assistance (SAGA) programs. "We have a very robust PDL with pretty much all of our manufacturers participating," Mr. Starkowski says. "Once we coalesced our pharmacy under one umbrella, it was easier to go to the manufacturers, and say, 'Here's the population that your drug can now be going to. Here's the volume that will be administered in a particular year. What can you do for a supplemental rebate?' That's worked fairly well for us." ■

New consortium finds common ground in quest to advance medical homes

Eight state teams are setting out to increase their Medicaid and Children's Health Insurance Program (CHIP) enrollees' access to high-performing medical homes. They will do so, in part, by learning from the experience of eight state teams who came before them.

The new teams, from Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia, are participants in the Portland, ME-based National Academy of State Health Policy's (NASHP) Consortium to Advance Medical Homes for Medicaid and CHIP. Last year's teams, from Colorado, Minnesota, New Hampshire, Oklahoma, Washington, Idaho, Louisiana, and Oregon, will share what they learned as part of the original consortium.

For example, the teams helped to identify what states could do to support and facilitate Medicaid access to medical homes, an enhanced model of primary care that provides comprehensive and coordinated patient-centered care.

"There is such incredible enthusiasm on the part of Medicaid and CHIP agencies on advancing this. And the first group of eight were really on the leading edge and made good progress," reports **Neva Kaye**, senior program director at NASHP.

"Now, a second group of states has made a firm commitment to advancing medical homes. This really will be like putting their projects in a hothouse," says Ms. Kaye. "The lessons learned by that first round are now being given to the second round, who I'm sure will come up with their own innovations as well. This new round of states will be building on that, but will also bring their own ideas."

Different approaches used

While the exact criteria for a medical home might differ somewhat from state to state, Ms. Kaye says that "there is a lot of commonality. Their criteria really does center around the primary care physician serving as the main point of contact for the patient."

However, Ms. Kaye says that the variation in reimbursement models used by states was somewhat surprising to her. "I went into this thinking they would probably coalesce around one reimbursement model, but they didn't. Essentially, there are three major models they are using to reimburse providers for billing as a medical home, with other elements, such as pay-for-performance and shared savings, that can be used within each of those three."

Ms. Kaye says the reimbursement approaches chosen by states often reflect the specific goals they wish to achieve. For example, if they want to encourage providers to actually see the patient, they may give a visit rate incentive, in addition to paying for the administrative cost of being a medical home.

States also varied widely in their targeted population. "I expect variation when I look at states, but not as much as I saw in this," says Ms. Kaye. "And I think there are reasons for that variation." As with reimbursement, this too depends on the particular goals of the state. While Minnesota started with individuals with the most complex needs, it is now looking to expand to other populations. Other states focused on children first, because they thought they could achieve success most quickly with that population.

"The other thing that surprised me is that several states intend to continue to expand this, so the work not only ultimately impacts Medicaid and CHIP beneficiaries, but individuals with private coverage as well," says Ms. Kaye. "This is a real deliberate strategy on the part of the states."

Evaluation is challenge

"What states are really trying to get at is, does this make a difference in outcomes? And I clearly see that is a struggle for them," says Ms. Kaye.

A diabetic being less likely to visit an ED is one clear indication of savings, but even more dramatic savings are possible over the long term if a primary care physician is able to keep that patient healthy in the first place.

However, short-term change needs to happen quickly enough so that the state can determine in the next year or two whether they are going in the right direction. "My sense is that the states really do look at this as an investment," says Ms. Kaye. "They understand that the outcomes they are working on take time to produce, particularly when you consider that one of the outcomes is the delay or prevention of

conditions such as diabetes."

Another challenge is how to support patients in being part of a medical home, in order to empower them to more actively participate in their own health care. "The patient needs to play more of an active role in the interaction with their primary care physician, to be part of the decision making. States are clearly interested in that," says Ms. Kaye.

Using practice coaches to help primary care physicians (PCPs) consider different ways to help patients become more engaged is one possible approach. Another involves learning collaboratives, which bring practices together to become higher-functioning medical homes.

The bottom line, says Ms. Kaye, is that "there is clearly an evidence base that says this will make a difference. There are always questions as to how it would roll out in each individual state. But there is solid evidence that this is the right direction to go in."

Iowa plans to spread its primary care medical home model as a standard of care for all citizens as a major component of its health care reform, beginning with children enrolled in Medicaid. However, budget shortfalls may hinder the state's progress to some degree. Due to a 10% across-the-board cut ordered by the state's governor, $132 million will be lost by the department, half of it in Medicaid.

"We believe implementation of medical homes is critical to improving coordination and management of care for Medicaid members with chronic disease," says Iowa's Medicaid director **Jennifer Vermeer**. "We expect to see better quality of care and improved outcomes for our members. But the biggest challenge will be implementation of a new strategy with very limited ability to provide financial incentives for providers, due to the shortage of state funds."

Alabama is looking to strengthen its well-established Medicaid primary care case management program, Patient 1st, in place since 1997. The program already includes designated primary care providers, sharing of information via electronic medical records, and payment incentives.

"The biggest thing we are going to get from this is the ability to take it to the next level," says **Kim B. Davis-Allen**, director of the Alabama Medicaid Agency's Transformation Initiatives Division. "It has always been a very informal type of program, and this is the chance for us to formalize it. We will also be partnering with the CHIP program, which is administered by the Alabama Department of Public Health, to create synergy among our common providers."

Although the program's concept has changed little since its inception, it's become evident that providers require additional tools. "A classic example of that is data," says Davis-Allen. "We want them to be able to manage patients, and to do so, providers need good, usable, timely information about those patients."

For this reason, Alabama is going to focus on identifying what resources its practices need to be high-functioning medical homes and also developing quality measures to demonstrate results.

In some cases, practices are providing care consistent with the medical home model but aren't getting recognized as such. For example, rural physicians may do a great deal of care coordination with other providers, including addressing the transportation needs of patients who have to travel to see specialists. "Once we can come up with a really good definition and key indicators, I think we'll find a lot more of our physicians can be classified as a medical home," says Davis-Allen.

Nancy Wikle, care management supervisor for Montana's Department of Public Health & Human Services, says that her state plans to implement systemwide change with its established medical home programs. "A medical home allows patients to become more involved in their health care. A cost savings can be realized when tests are not repeated, urgent and emergent care services are decreased, and referrals to specialists are only given when medically necessary," she says.

However, Montana also faces unique challenges, because it is a geographically large state with a limited number of PCPs. "We do frequent site visits and trainings and share information with providers about how they can serve as an effective medical home to their clients," says Ms. Wikle. "We

encourage and support only medically necessary referrals to providers other than the PCP, when the PCP cannot furnish such services. But we want more guidance on other ways to support practice change."

Better client outreach is needed to educate individuals about the importance of a medical home, and why the utilization of one primary care provider will improve their health. "We want to explore enhanced reimbursement, in order to get providers on board with the medical home concept and define methods to certify a physician's practice as a medical home," says Ms. Wikle. "We expect to see healthier Montanans and a cost savings."

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Report validates the value of Medicaid health plans

Medicaid health plans improve quality and yield cost savings ranging from half of 1% to 20%, according a March 2009 report from The Lewin Group in Falls Church, VA, "Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies." Researchers analyzed 24 existing studies to determine the savings achieved when states have implemented private Medicaid health plans.

Cost savings were mostly due to two factors: Drug costs and changing patterns in unnecessary inpatient utilization. In addition, Medicaid health plans earned high satisfaction ratings from enrollees.

Joel Menges, the report's lead author and a managing director at The Lewin Group, says the studies were all consistent in finding positive outcomes. "Most of the studies found savings in the range of 3% to 8%, but all did find savings," he says.

Currently, only about 20% of Medicaid money is paid through the capitation vehicle to health plans. "So, 80% of Medicaid's money is still in the traditional fee-for-service environment," says Mr. Menges. "In a situation where states are taking various kinds of axes to the Medicaid program to deal with their budget crises, a significant opportunity exists in most states to expand the use of capitation. Money can then be saved in a constructive, rather than destructive, way."

One obstacle is a strong public perception that the HMO model prevents needed care from happening. "I don't think of any of the studies we have seen are validating that concern, but that has been a significant barrier to the expansion of managed care," says Mr. Menges. "The general feeling toward the HMO industry as a whole, in the public eye, is much more negative than positive. But the reality of the model is that it is generally working quite well for the people it is serving."

Mr. Menges argues that plans can only achieve savings by keeping people healthy, avoiding unnecessary services, and treating minor issues effectively so that they do not snowball into full-blown health crises "which, unfortunately, the fee-for-service Medicaid model doesn't do a good job of averting."

More managed care needed

While only 20% of Medicaid money is capitated, roughly 50% of the Medicaid population is served in managed care. Mr. Menges says that one reason for this is that the disabled and other high-need Medicaid subgroups have largely not been moved over to the capitated setting.

"A good case can be made that we've got the least Medicaid managed care where we need it the most, for the sicker populations," says Mr. Menges. "That is where the hesitancy is particularly high, to put needy and vulnerable people in the hands of HMOs, but I think that's a misguided fear. The reality of the model is, when it's designed well, implemented by capable and experienced MCOs and monitored adequately, it can work extremely well for high-need populations."

Mr. Menges says the current health care reform movement is focusing heavily on only one major problem in the health care system—that of covering the uninsured. "The second devastating problem that our system costs too much. It is not organized to create effective, efficient results," he says. "In my view, a huge need exists to ramp up the cost-effectiveness that the Medicaid and Medicare programs are achieving per person, particularly if health care reform is going to succeed in covering even more people. There is a need to refocus more firepower on programs that achieve cost-containment."

Public distrusts HMOs

The public's distrust of HMOs is so deep-rooted, it's unlikely to be swayed by any evidence to the contrary. However, Mr. Menges says the overall performance of the capitated model has been at least equal, if not better, than the fee-for-service model, on both quality and cost-containment.

"I think that will eventually win out in the political arena, though I don't have a crystal ball of how long

it will take," says Ms. Menges.

One roadblock is that the public lacks an understanding of the difference between Medicaid managed care and private sector managed care. "I think the model of coverage, whether it's Medicaid, Medicare, or elsewhere, where people can go wherever their coverage card is accepted, providers can perform whatever services they choose, and other people's money just pays for it all, that can't be cost-effective wherever that model is used," says Mr. Menges. "That model is used quite heavily in the Medicaid program right now, and I personally think that needs to change."

The Medicaid managed care industry is—and should be—a highly regulated industry, adds Mr. Menges. "Given that impoverished and highly vulnerable people are being served, there is an important need for careful design, thoughtful selection of the health plans, close monitoring and so forth," he says. "It needs to be done properly and carefully. But when it is done that way, it performs very well."

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Extra diagnostic testing can cost hospitals big

Hospitals are losing large amounts of money on extra and inappropriate diagnostic testing and procedures, as well as outpatient procedures performed in the inpatient setting, because third-party payers frequently are denying the claims, says **Brenda Keeling**, RN, CPHQ, CPUR, of Patient Response, a Milburn, OK, health care consulting firm.

"Case managers should be on the lookout for unnecessary resource utilization, because their hospitals aren't going to get paid for it. If they see something in the chart that might be questionable, they should query the physicians about it," she says.

"Often patients come in with one acute care diagnosis and the physician orders diagnostic testing for other complaints that have no correlation to the acute care condition that prompted the admission," Ms. Keeling says.

For instance, a patient may come in with pneumonia and complain of having back pain for six months, so the doctor orders an MRI. The chronic back pain has nothing to do with the acute reason the patient is hospitalized, so the hospital is utilizing expensive resources for which there will be no additional reimbursement, she adds.

MRIs of the extremities or the spine for chronic pain rarely can be justified in the acute care setting unless the patient was recently injured, Ms. Keeling says.

Another example would be a patient who comes to the emergency department with a possible gastrointestinal bleed, is hospitalized, and receives an esophagogastroduodenoscopy (EGD). ■

OSHA enforcing N95 respirators for HCWs treating H1N1 flu patients

OSHA: 'We're looking for a good-faith effort.'

By **Gary Evans** and **Michelle Marill**
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Hospital Infection Control & Prevention
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Particulate respirators — a controversial step beyond common surgical masks — are now mandated by the Occupational Safety and Health Administration (OSHA) to protect health care workers from acquiring H1N1 pandemic influenza A from patients. With respirator shortages feared, "good-faith efforts" by health care employers will be recognized by OSHA, which nevertheless is warning that citations and fines may result from inspections that will be primarily prompted by employee complaints.

"Employers should do everything possible to protect their employees," said **Jordan Barab**, acting assistant secretary of labor. He emphasized, however, that where respirators are not commercially available, an employer will be considered to be in compliance if the employer made every effort to acquire respirators. Health care employers will need to be able to show documentation of orders that have been placed or statements from a manufacturer that the respirators are on back order. N95 respirators — already used by many hospitals for the treatment of tuberculosis patients — are the minimum level acceptable for H1N1.

"We're looking for some evidence that the employer has attempted to purchase N95 respirators," Barab said. "We're looking for a good-faith effort."

OSHA is issuing a compliance directive to enforce the Centers for Disease Control and Prevention's recently issued "Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel." (Available at http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm.)

The CDC disappointed infection preventionists in the guidance by reaffirming its stance that surgical masks are not sufficient to protect workers from H1N1 patients. The CDC recommends the use of respiratory protection that is at least as protective as a fit-tested disposable N95 respirator for health care personnel who are in close contact (within 6 feet) with patients with suspected or confirmed 2009 H1N1 influenza. The president-elect of the Society for Healthcare Epidemiology of America said the CDC decision appeared to be made for reasons other than science, which has not shown burdensome, scarce N95s to be more effective in clinical studies.

"They are recommending a respirator that is not readily available, for transmission that has never been shown to be clinically relevant," said **Neil Fishman**, MD. "It presents a hardship to health care workers and health care providers that is unnecessary and offers nothing in [additional] degree of protection."

On the other hand, the CDC is under considerable pressure from health care unions and worker safety advocates since at least four nurses nationally have reportedly died of complications related to H1N1. Noting that H1N1 surveillance systems do not provide occupational data, the National Institute for Occupational Safety and Health (NIOSH) is asking for information from the public on health care worker H1N1 illnesses and deaths. (Information can be e-mailed to nioshh1n1data@cdc.gov.) NIOSH is asking for contact information so the agency can follow up on cases that have primarily been reported through the media.

"Once we get that information, we can make decisions about whether we want to do a more thorough investigation, whether it is a Health Hazard Evaluation or another kind of study," says **Christina Spring**, health communications specialist with NIOSH in Washington, DC.

Meanwhile, OSHA inspectors will ensure that health care employers implement a hierarchy of

Supplement to *AIDS Alert, Critical Care Alert, Clinical Trials Administrator, Contraceptive Technology Update, Case Management Advisor, Discharge Planning Advisor, Drug Formulary Review, ED Nursing, ED Management, ED Legal Letter, Emergency Medicine Reports, Hospital Case Management, Hospital Peer Review, Hospital Medicine Alert, Hospital Home Health, Healthcare Risk Management, Infectious Disease Alert, IRB Advisor, Medical Ethics Advisor, Occupational Health Management, Patient Education Management, Primary Care Reports, Pediatric Emergency Medicine Reports, Same-Day Surgery, State Health Watch,* and *Travel Medicine Advisor.*

controls, including source control, engineering, and administrative measures, and to encourage vaccination and other work practices recommended by the CDC. Where respirators are required to be used, the OSHA Respiratory Protection standard must be followed, including worker training and fit testing. While the ruling clearly applies to hospitals, as this report was filed OSHA had not responded to a written request for clarification regarding other medical settings. Employee complaints from clinics and physician offices could potentially result in an inspection because OSHA's respiratory protection standards also apply to small businesses.

CDC casts wide net

The CDC clarified that the scope of its guidance includes a wide range of medical settings: "This guidance provides general recommendations for health care personnel in all health care facilities," the CDC stated. "For the purposes of this guidance, health care personnel are defined as all persons whose occupational activities involve contact with patients or contaminated material in a health care, home health care, or clinical laboratory setting."

Since a shortage of disposable N95 respirators is possible, employers are advised to monitor their supply, prioritize their use of disposable N95 respirators according to guidance provided by CDC, and to consider the use of reusable elastomeric respirators and facemasks if severe shortages occur, OSHA advised. Health care workers performing high-hazard, aerosol-generating procedures (e.g., bronchoscopy, open suctioning of airways, etc.) on a suspected or confirmed H1N1 patient must always use respirators at least as protective as a fit-tested N95, even where a respirator shortage exists. In addition, an employer must prioritize use of respirators to ensure that sufficient respirators are available for providing close-contact care for patients with aerosol-transmitted diseases such as tuberculosis.

Where OSHA inspectors determine that a facility has not violated any OSHA requirements but that additional measures could enhance the protection of employees, OSHA may provide the employer with a Hazard Alert Letter. OSHA will inspect health care facilities under the Respiratory Protection Standard "to ensure that health care workers are protected and that protection is in line with CDC [guidance]," Barab said.

The CDC guidance to use respirators has been controversial and hotly debated almost since the onset of H1N1 last spring. Many infection preventionists argue that H1N1 is comparable to seasonal influenza in its virulence and transmission routes, and that droplet precautions (e.g., surgical masks) are sufficient. In fact, some state health departments diverged from CDC and called for surgical masks unless health care workers were performing aerosol-generating procedures.

The Healthcare Infection Control Practices Committee, a CDC advisory panel, endorsed the use of surgical masks rather than respirators. But an Institute of Medicine (IOM) panel charged with reviewing the available science concluded that surgical masks would not protect workers from airborne influenza particles. "[T]here is evidence that work-related exposures to patients infected with H1N1 virus result in health care workers becoming infected," the IOM report stated.

The answer, decided CDC director **Thomas Frieden**, MD, is to use respirators but to limit their use through other measures. "Use a scarce resource carefully," he said in a briefing on the guidance. "Follow a hierarchy of controls and limit the number of people who are potentially exposed and would need a higher level of protection."

The CDC is no longer recommending contact precautions — the use of gowns and gloves — but Frieden noted that influenza is spread through droplet, fomite, and aerosol transmission. "It is an unfortunate fact that we do not have definitive evidence on the portion of transmission that occurs from each of those three routes," said Frieden, noting that "the preponderance of belief" was that droplets were the most common route. "With that lack of knowledge and with the newness of H1N1 . . . we are recommending that N95s . . . would be clearly superior to surgical masks."

Still, CDC is providing some flexibility to hospitals. That means in some circumstances, health care workers may reuse respirators, continue to wear them while caring for more than one patient, or may even wear surgical masks as a last resort option. CDC states that extended use (in which the respirator is not removed while the health care worker cares for more than one patient) is preferred over reuse.

"We recognize that there may be shortage situations," said Frieden. "The need is for us not just to provide respiratory protection now, but the flu season lasts through May. We need to ensure we have a reliable supply."

The CDC guidance states that "when in prioritized respirator use mode, respirator use may be temporarily discontinued for employees at lower risk of exposure to 2009 H1N1 influenza or lower risk of complicated infection." ■