State Health Watch
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Will Medicaid take full advantage of HITECH funding—or not?

Will funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), propel state Medicaid programs forward with the use of electronic health records (EHRs)? Or will state fiscal crises or other unforeseen problems prevent the hoped-for progress?

The answer probably is a little of both, but efforts are redoubling now that the Centers for Medicare & Medicaid Services (CMS) actually is releasing funds to Medicaid programs.

The HITECH funding "provides momentous opportunities, significant funding, immense expectations, tight time frames, and huge financial and human resource demands on state Medicaid programs, CMS, and Medicaid providers," says **Patricia MacTaggart**, a lead research scientist/lecturer at George Washington University's Department of Health Policy in Washington, DC. "The potential is great for real transformation in health care, health care delivery, and health care administration."

There is 90% federal funding for administrative activities, including oversight and promotion of health

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Arizona's Medicaid program struggles to maintain itself in face of 'fiscal challenge'

Thomas J. Betlach, director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, says he has these goals for the program: To keep providers in the system, to keep an integrated model, to maintain competition among health plans, to pay appropriately, and to ensure access to care.

Fiscal Fitness: How States Cope

"We are dealing with a problem of a magnitude that has never been faced in the state before," says Mr. Betlach. "But even though the state is facing this incredible fiscal challenge, I think there is a general recognition that the program that we have works well. And we need to keep the core fundamentals of that program in place."

"The legislature has been dealing with a structural imbalance that they have largely used one-time funding sources to address. It's almost $5 billion in shortfalls that they need to deal with," says Mr. Betlach. "That may seem like a small amount of money compared to California, but it's a huge percentage of our overall revenue."

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information exchange, and 100% federal funding for provider incentives. However, for providers to get incentive payments in 2010 for adopting, implementing, and upgrading certified EHR technology, states must have a process and infrastructure for administering and disbursing the incentive payments to Medicaid providers. At the same time, duplication of payments made through Medicare must be avoided.

'Meaningful use'

States are now sorting through the Office of the National Coordinator's Interim Final Regulation relating to HIT standards, implementation specifications, and certification criteria, and CMS' proposed rule on the Electronic Health Record Incentive Program for Medicare and Medicaid programs, often referred to as the "meaningful use" Notice of Proposed Rulemaking.

"They are identifying and clarifying numerous governance, legal, policy, technical, and business process complexities, while educating their stakeholders, including governors, state legislators and their own staff, on what must be done, by when, and how many state dollars will be needed," says Ms. MacTaggart. "They are balancing doing it quickly with doing it well, and they are doing it with limited staff in an economic environment that is stretched."

As for the proposed meaningful use regulation, Ms. MacTaggart says CMS "did a great job of clarifying many things and requesting comments on areas where there is more than one option being considered."

It will be important for states and providers to review the proposed language, understand the terminology, and comment on feasibility related to operational issues, time lines, and interdependencies with other regulations and activities. These include certification and standards of EHRs, and the commonalities and differences between Medicare and Medicaid.

For instance, the "payment year" for eligible hospitals refers to the federal fiscal year, but the payment year for eligible professionals is the calendar year for both Medicaid and Medicare. "For Medicare, the second payment year is the second year of meaningful use, while for Medicaid it can be the first year of meaningful use following one year of adoption, implementing, or upgrade of certified EHR technology," adds Ms. MacTaggart.

Ms. MacTaggart says "the best potential for real change that is sustainable" is through the use of HIT, with Medicaid either leading or playing a critical role. "This is a rare opportunity to work interstate as well as intrastate to develop, design, and implement a framework that supports the policy goals, rather than adjust the policy goals to work within the infrastructure available," she says.

For example, instead of fixing 50 state eligibility systems one at a time, or creating "workarounds" to accommodate their individual failings, Ms. MacTaggart says "we can get together, state and federal, and create an eligibility system that can support health care reform demands for all states. This results in immediate standardization of a data source and paying for it once rather than 50 times."

Georgia Medicaid is currently working on getting systems in place to keep track of who is getting incentive payments, whether providers are using a certified EHR system, and whether they are com-

plying with the federal meaningful use definition, reports **Rhonda M. Medows**, MD, FAAFP, commissioner of the Georgia Department of Community Health (DCH).

At the same time, a reimbursement method needs to be developed to pay providers the appropriate incentives. "Once there is a system in place, providers will get a higher Medicaid rate, which is excellent. Financing someone to do something definitely is a strong motivator to get them to do it," says Dr. Medows. "But, it means our claims system has to be able to incorporate a higher payment for them."

No silos for Medicaid

Dr. Medows says she thinks the biggest challenge involving HIT and Medicaid at this juncture is "to make sure we don't allow ourselves to silo things. The whole definition of HIE, after all, is that information is getting exchanged."

For state Medicaid programs, Dr. Medows says that the challenges are in large part "the same as you see at the national level, of getting providers as well as plans to see the value in the short term and in the long term, for having HIEs and using EHRs, as well as e-prescribing and other tools for communicating."

A large push was made to keep Georgia Medicaid providers apprised of all of the various grant opportunities, so they don't miss out. "We have made an incredible effort to notify all of the 40,000 physicians in the state of Georgia every step of the way. We have kept them up to speed with advisory meetings, web sites, and e-mails," says Dr. Medows. "We make sure that they know there are incentives, but there is also the possibility of reduced reimbursement if they are not on board."

According to **Rod Prior**, MD, Maine's Medicaid medical director, the planning funds from CMS "provide a great opportunity to improve Maine state government's own HIT systems. Previous and impending funding cutbacks in the Maine state government budget have sharply limited our ability to invest in long-range planning and strategic system development," he says.

Maine's Department of Health and Human Services has submitted a preliminary Advance Planning Document to CMS to set up a planning team for HIT systems over the next one, two, and five years.

Currently, an HIE called Health InfoNet is being piloted. The system connects Maine's major hospitals, most public health immunization records, pharmacy data, and one integrated delivery network of primary care, all made possible through HITECH funding.

"We became operational last summer. This HIE will be the foundation of an effort to spread or expand the capacity to reach all providers in the state," says **Jim Leonard**, program manager of the Maine Quality Forum in Augusta and interim director of the Office of the Coordinator for HIT. "Within the next four years, we are certainly hoping to have the whole primary care system connected."

As the ARRA funds need to be committed by March 2010, "a number of new funding opportunities have been released simultaneously and are due back to the Office of the National Coordinator quickly," he says. "There is also funding to provide regional extension centers to provide direct support to practices that are needing help, particularly those practices which will be delivering services to the underserved population—what would be called the safety net providers. This is where a lot of the Medicaid population is actually served."

In terms of where he expects HIT will make an impact on Medicaid, Mr. Leonard notes that as the average age of the Medicaid population is relatively young compared to populations that are commercially insured, "one thing that becomes important is services to children." Another possible opportunity for Maine Medicaid involves working with a state university to develop an approach to use new clinical measures recently developed by the Agency for Healthcare Research and Quality to improve care of children. A related goal is incorporating Bright Futures, a set of quality measures related to kids with developmental issues.

Another one of Maine Medicaid's HIT goals is better management of people with chronic diseases. "We did one study that showed that the proportion of diabetes in the Medicaid population was about 7%, higher than the statewide average. That is unusual, as it's a younger population," Mr. Leonard says. "The cost was 14% of the overall cost. So, you had a portion of the population that was twice as costly as the statewide average."

When will cost savings come?

While HIT alone can't address the current budget shortfalls states are facing, it *is* an important component in making health care delivery more efficient. In Arizona's case, **Perry Yastrov**, project director of EHR Systems and Services for Arizona Health Care Cost Containment System, the state's Medicaid program, says, "The state faces one of the biggest deficits in the United States. HIT has the ability to help in the long run but will not be able to provide savings for the immediate crisis."

Robert L. Robinson, PhD, executive director of Mississippi Medicaid, says that the program's

biggest challenges right now are "an increasing number of eligibles, increased medical costs, and decrease in funding due to shortfalls in our state's budget." Currently, the Division of Medicaid is wrapping up the initial pilot of its electronic prescribing program, which targeted about 250 providers.

In addition, the Division of Medicaid will roll out a new EHR/e-prescribing solution statewide in April 2010. "We anticipate the HITECH incentives to provide additional momentum towards widespread e-prescribing adoption," Dr. Robinson says.

The program provides point-of-care access to critical drug information, interaction screening tools, current medication histories, preferred drug lists, and clinical decision support tools. Here are results seen by Mississippi Medicaid a year after the e-prescribing program was implemented:

—more than $1.2 million a month was saved in prescription drug costs;

—about $922,000 in hospital costs was saved from the system's "high" and "very high" drug interaction alerts;

—more than $14.4 million was saved, due to the ability to prescribe fewer and less costly medications.

Dr. Medows predicts that HIT will eventually result in cost savings for Georgia's Medicaid program, but she says the primary focus right now is care delivery. "There is an assumption that if you give treatment that is effective the first time, you basically avoid complications from delaying care or duplicating tests," she says. "So, there is an intuitive sense there would be a cost savings. But our ultimate focus is on bringing health care delivery up to 21st century standards. This is an amazing communication tool that every other industry uses. We have not taken full advantage of it yet."

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HIEs used by Medicaid must coordinate with others

Any Health Information Exchange (HIE) system utilized by Medicaid will need to coordinate with others in the state, including those developed by public health programs and private health plans. "Medicaid can't operate in a vacuum, and neither can the other programs," says **Rhonda M. Medows**, MD, FAAFP, commissioner of the Georgia Department of Community Health (DCH). "It sounds tough, but it's doable. Like any major challenge, you have to take it step by step, in logical sequence."

Georgia's Medicaid Health Information Technology (HIT) planning grant of about $3 million will address the coordination of HIE systems statewide. The next step is implementation. "So, after we finish coming up with a plan and get CMS to approve it, the next thing we compete for is an HIT implementation grant," says Dr. Medows. "That will be very important, because that is the money to actually make it real. Medicaid will be able to plug in on one side, state health employee plans on another side, and payers will plug in as well. Information will be exchanged across all of those for an individual patient."

The capability to obtain aggregate information on public health community assessments is going to be built in from the beginning, as this can be used for emergency planning. "That will give us important information on the health status of our community," says Dr. Medows. "That is going to be a really, really exciting area. We are going to be getting all the folks together at a table, so this actually becomes a reality."

Single infrastructure

Perry Yastrov, project director of EHR Systems and Services for Arizona Health Care Cost Containment System, the state's Medicaid program, says it has become painfully clear that the state lacks resources for multiple HIEs with functionally redundant infrastructures. Therefore, a collaborative effort is under way with the Southern Arizona Health Information Exchange and other stakeholders. The goal is to build a single HIE infrastructure, as opposed to multiple, interoperable HIEs.

The objective is to leverage the Arizona Medicaid Information Exchange, which was funded by a Medicaid Transformation Grant, as much as possible, as well as incorporating work that has been accomplished by other HIE initiatives in the state. "Health information will be easily reused for treatment and care management purposes," says Mr. Yastrov. "The benefit to Medicaid will be a healthier membership, lower cost, and improved outcomes for its members."

The Regional Extension Center funds will be used to support and accelerate the adoption of interoperable EHRs. Mr. Yastrov adds that the Purchasing & Assistance Collaborative for Electronic Health

Records, another product of the Medicaid Transformation Grant, is in a good position to deliver the services required.

Ultimately, the HITECH funds "will allow the initiatives that were germinated by the Arizona Health Care Cost Containment System, Arizona's Medicaid agency, to continue, and to broaden their scope to health care providers across all of Arizona," says Mr. Yastrov. ■

Fiscal Fitness

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The state has just eliminated coverage for its CHIP parents program, which it had implemented through waivers. This resulted in about 10,000 people losing coverage. A "cap and freeze" was implemented for the CHIP program, which currently covers about 45,000 kids. "We are projecting that by the end of the fiscal year on June 30, we'll be down to below 30,000 just in terms of attrition with that program," says Mr. Betlach. "Another area that has taken a hit is administrative resources. We have gone from a staff that manages Medicaid programs in Arizona of about 1,350, to below 1,100."

MOE is an issue

As for funding from the American Recovery and Reinvestment Act (ARRA), Mr. Betlach says this has been "a double-edged sword" for AHCCCS. "The $2 billion we are receiving to support our Medicaid program has been instrumental in allowing the legislature to deal with the deficit," he says. "But at the same point in time, the maintenance of effort requirements, in conjunction with the constraints that the voters have approved, limits the legislature's ability to do much with regard to eligibility."

Due to those requirements, a number of discretionary cuts were taken off the table. For example, Arizona is one of only six states that cover up to 100% of the FPL for childless adults. "So, we do have a bit of discretionary spending with regards to optional spending at the federal level," says Mr. Betlach. "But between maintenance of effort and what we call voter protections, the legislature's hands are relatively constrained with regards to eligibility."

Some minor changes were made to benefits during the last round of budget cuts, most of them involving tightening up of medical necessity requirements. "But to a large extent, when the legislature has talked about benefits, there hasn't been the political will with regards to making any significant changes. That would have required making statutory changes," says Mr. Betlach.

Already, the state's governor has recommended a change for the FY 2011 budget involving the program's expansion of up to 100% of the FPL. This was originally funded with tobacco settlement money, but state general funds ended up being used to supplement that funding. The governor plans to ask the voters to revert back to the tobacco settlement as the sole funding source.

"That would drop about 300,000 people from coverage, after the maintenance of effort requirement from the stimulus dollars goes away on Jan. 1, 2011," says Mr. Betlach. "Obviously, health care reform is a whole separate discussion that could potentially impact that policy decision."

Growth continues

Provider rates were reduced about 5% across the board for the most part, with hospitals and nursing home rates maintained. While access is being closely monitored, no particularly troubling issues have been detected as yet. This is possibly due to a lot of effort made to keep providers apprised on the status of the state's fiscal status.

"To a large extent, they understand and recognize the situation. Or in some areas, Medicaid may be the majority source of their funding, and they may not have a lot of options," says Mr. Betlach. "I think that overall, people recognize that they are having to make similar decisions to the type of decisions we have had to make, in terms of staffing levels and those types of things. At the same time, you still have to continue to meet the workload requirements."

Meanwhile, Medicaid enrollment continues to grow. In 2008, recipients increased by 100,000, and in 2009, an additional 210,000 individuals were enrolled. The most recent four months saw increases ranging from 12,000 to 25,000.

"It has been occurring over the last 24 months on a pretty steady basis; then it really accelerated in this last year," says Mr. Betlach. "We've had a lot of growth across the board. The biggest growth area is in childless adults." The only exception is the CHIP program, which even before the "cap and freeze" was implemented, had shrunk by about 12,000 members. This is attributed to individuals moving into the Medicaid program as their income drops off.

As for the state's revenue, "I think we're down almost 40% now in terms of our general fund collections revenue over the last three years. We are back to our FY 2004 revenue collections," says Mr. Betlach. "And we've got 140,000 more kids in the K-12 system and 470,000 more people on Medicaid. So, that is the balancing act that the legislature is trying to address. We are seeing

poor revenues, along with significantly increased demand for state-funded services."

Program is at crossroads

While Mr. Betlach sees HITECH funding as an opportunity for Medicaid to reduce costs and improve quality, considerable challenges remain. "It's a matter of marshaling the resources necessary to make that happen. We need to make sure we can pay the providers the incentive payments they have earned when they can demonstrate they have met meaningful use," he says. "We need to be sure that providers understand what type of opportunities exists under the law."

A major worry is the ARRA "cliff" when funding ends on Jan. 1, 2011. "That is a huge issue for states. It has a significant impact on our program," says Mr. Betlach. "That funding was put in there to try and help states during this difficult economic time, but unemployment is still at 10% nationally. And states are continuing to try and deal with the structural deficits that they have."

On the health care reform front, Mr. Betlach says he's concerned that both the House and Senate bills require states to maintain the programs that were in place as of 2008, before the full impact of the recession was felt.

"That is an incredible challenge for states. How you bridge that time frame and how you make that work, given the budget challenges we're facing, is something that our policymakers will really struggle with, especially if there [are] no additional funds during that bridge period," says Mr. Betlach. "Then, when you get to the expansion period, especially under the Senate bill, Arizona is really negatively impacted."

The concern is that states that have pursued expansion policies will be unfairly penalized. "We are basically told to continue to fund the expansion that we started a decade ago. Even though we pursued a policy that Congress is now trying to pursue, we're told that we need to continue to fund it at traditional match, instead of getting the increased funding that other states will," says Mr. Betlach.

When it comes to its expansion programs, such as covering childless adults, Arizona is at a crossroads. "We will either have the federal government coming in and mandating a program that we can't afford without additional assistance from them, or the governor talking about the need to roll this back, because we can't afford this program," says Mr. Betlach. "The next several months will be very interesting for the state of Arizona, in terms of shaping the future of health care coverage."

There is little doubt that Arizona, in comparison to other states, is in for a slower recovery in terms of the rebalancing of the real estate market, both commercial and home, he notes. "This recession, as compared to others, has been incredibly deep," says Mr. Betlach. "With just about every other recession, at this point in time we were back to employment levels seen as pre-recessionary; whereas, the impact now is just staggering."

The direction the AHCCCS program goes is dependent on what transpires over the next six months, says Mr. Betlach. "It depends on how the state responds to its fiscal crisis, and potentially, what the fed[eral] government dictates to the states. It is a very serious situation."

Despite these fiscal challenges, the hope is for Arizona's Medicaid program to remain as unchanged as possible. "That is the main thing we are focused on," says Mr. Betlach. "With regards to managed care, it has been a model that has served this state well in terms of our ability to contain costs, while providing good services to members and good reimbursement to providers. Our goal, over these next challenging few years, is to maintain that core model."

Contact Mr. Betlach at (602) 253-2570 or Thomas.Betlach@azahcccs.gov. ■

Break barriers to incentives: Ask providers what they need

Medicaid providers may be eagerly awaiting incentives to purchase electronic health records (EHRs) for their practice, as a result of funding from the HITECH Act. However, at this juncture, some troubling questions remain.

"Let's say I'm a doctor, and I have all these vendors knocking at my door wanting to sell me this product. How do I know which one is best?" asks **Chris Collins**, deputy director of North Carolina's Office of Rural Health and Community Care and assistant director of the Division of Medical Assistance—Managed Care. "Also, who's going to install it? Who's going to teach me to use it? And where is the work force, in very rural communities, to support the upgrades?"

Medicaid directors are grappling with the best way to help their providers qualify for incentives. "This is one of the things that Georgia Medicaid is currently looking at. We want to get [those] providers who *don't* have a system currently, everything they need in order to get on board," says **Rhonda M. Medows**, MD, FAAFP, commissioner of the Georgia Department of Community Health (DCH).

As part of North Carolina's electronic prescribing initiative,

providers aren't left high and dry when it comes to ensuring the participation of local pharmacists. They are given a great deal of assistance when the system goes live as well.

"You've got to tie the provider to the pharmacy down the street. Otherwise, there is no point in putting you on the system," says Ms. Collins. "We also stay on site with them for four days when they flip the switch. So, there is a lot of hand holding, even with something as simple as e-prescribing. If you have a provider at ground zero with HIT, you can't ask them to climb Mt. Kilimanjaro to demonstrate meaningful use!"

A related concern is that the bar will be set too high for primary care doctors, whose pay is generally substantially lower than other providers. "Primary care providers are not wealthy, and often they are the communities' safety-net providers," says Ms. Collins. "So, if they are going to make a bigger investment than others, that is going to be a real challenge for them. On the positive side, resources are going to be dedicated for this. It's not necessarily an unfunded mandate."

While some areas of the state have good primary care access, in some rural areas, there are no primary care doctors to link patients to. The same is likely to be true for HIT. "There are work force issues around primary care and qualified mental health providers. And I think you will find work force issues around HIT, not in terms of the vendors, but the person who will help you out if your system is down," says Ms. Collins.

ID needs, ASAP

Georgia Medicaid has received funding for a Regional Extension Center to help with provider adoption outreach and training. This is particularly aimed at small provider groups and those that care for underserved populations. The National Center for Primary Care at Morehouse School of Medicine in Atlanta is the primary applicant, as a nonprofit entity. "But the state is also a partner, because a lot of small group practices who care for the underserved are Medicaid providers," says Dr. Medows. "We have a common goal: to make sure they have all the tools they need to get on board."

Well before the grants became available, the largest medical associations in the state were asked the question, "What would it take for you to implement HIT?" They came up with 12 items that did not involve a direct payment.

Help with workflow assessments and technical support were two requests. "When you put EHR into somebody's office, you have to know how to use it and make it work in their practice," says Dr. Medows. "It would be great if states would ask providers in their community that question: What do they need other than cash? Then listen to them."

Providers also asked whether a group purchase could be made in order to get a discount, and whether the state would work with them on using Software as a Service web-based EHRs, which lease space, so it's not necessary to buy a separate server. "They didn't want to own their own servers. They don't want to worry about upgrading them or complying with the latest federal regulations, because the technology is changing every day," says Dr. Medows.

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Vermont puts long-term care on level playing ground

Vermont Medicaid has been able to make some important changes to the delivery of long-term care services, thanks to its unique Choices for Care waiver.

The 1115 Long-Term Care Medicaid Waiver is "a first in the country," according to **Brendan Hogan**, MSA, deputy commissioner of the Agency of Human Services' Department of Disabilities, Aging, and Independent Living. "We have equalized the entitlement to both nursing home and home and community-based options for individuals who are eligible for our waiver program." One result is that more people are being cared for in the community as opposed to nursing homes.

Budgets combined

Prior to Choices for Care, a 1915(c) waiver was in place, as in many states, to provide services under home and community-based services. Starting in 2005, though, the budgets for home and community-based services and nursing homes were combined. If an individual is eligible for the waiver, he or she is now given the choice of which setting to obtain long-term care.

"So, what we have now is a global budget to cover all long-term care in Medicaid," says Mr. Hogan. "And that is something that is unique to Vermont. We are the only state in the country that equalizes long-term care under Medicaid services. This levels the playing ground. Since the budgets are combined, the access to services is opened up, hence the reason for the name of the waiver, 'Choices for Care.' We believe it's been successful for several reasons."

For one thing, the number of people waiting for home and community-based services was reduced from several hundred to fewer than 100. "We still have a financial safety valve, for lack of a better term, that

allows us to control access based on the different eligibility groups we have," Mr. Hogan reports.

The arrangement took several years of planning and coordination with other departments to achieve, along with negotiations with both regional and national Centers for Medicare & Medicaid (CMS) offices. "But they were very willing to work out all of the details. We have recently submitted our request to extend our waiver for an additional three years," says Mr. Hogan.

The approach of combining long-term care funding into a single budget is likely to be adopted by other state Medicaid programs in the near future. "I believe there are other states looking at this. There are certainly discussions in long-term care and health care reform that speak to this type of arrangement," says Mr. Hogan. "We have been contacted by other states to ask us about some of the challenges."

Since the budgets are no longer separate, a global look is taken in terms of what is paid out for care, whether it is provided in nursing homes or the community. "We look at it as one budget. Because it's a 1115 waiver, we are provided the flexibility to do that," says Mr. Hogan. "Frankly, we found the cost of care servicing people in the community tends to be about half what it would be in a nursing home. By virtue of combining the budgets together and with less people served in the nursing homes, we have been able to stay within budget neutrality."

In order to be eligible for long-term care under Medicaid, an individual must be both clinically and financially eligible, so a two-step process is required. In Vermont, a three-tiered system for clinical eligibility is used, consisting of highest-, high-, and moderate-need groups.

The highest-need group consists of individuals who clearly require a nursing home level of care. "The high need are also a nursing home level of care, but as part of our waiver, it's the group that we are allowed to have a waiting list on. Currently, there are approximately 80 of this group on the waiting lists. There may be more people who may be eligible, but we have limited funds," says Mr. Hogan.

"We have had some nursing home diversion grants from CMS. There has been some ability to move some people out of nursing homes. But for the most part, it is more a sense of now that community services is an option and we are able to make it work, they are choosing it."

—Brendan Hogan

Deputy Commissioner, Vermont Agency of Human Services' Department of Disabilities, Aging, and Independent Living

In the past, individuals were automatically eligible to get into a nursing home, and the waiting list was only used for home and community-based services. "The wait would depend on funding, similar to what we have now, but it also depended on the turnover rate. Like many other 1915(c) waivers around the country, the turnover rate in terms of people enrolled tends to be about two years," says Mr. Hogan. "So, there are a lot of people who would have to wait until money was freed up by somebody leaving the waiver." Now the same waiting list is used for either setting.

The moderate-needs group is a smaller expansion group, whose members are not eligible for full long-term care Medicaid services. "For that group, we are providing people a certain amount of services —but not the full amount. We hope to prevent them from needing the full array of services," says Mr. Hogan. The theory is that if an individual is able to access benefits such as case management, adult day services, and personal care services on a limited basis, the need for full long-term care services will be delayed.

Most of the individuals eligible for long-term care in Vermont Medicaid are now opting for home- and community-based care, including residential care homes, as opposed to nursing homes.

"We have had some nursing home diversion grants from CMS. There has been some ability to move some people out of nursing homes. But for the most part, it is more a sense of now that community services is an option and we are able to make it work, they are choosing it," says Mr. Hogan.

Medicaid is working with its providers on the community-based side, such as adult day centers and residential care centers. "One part of our waiver involves consumer-directed and surrogate-directed care. Under that, we have a contract that allows people to hire their own personal care workers," says Mr. Hogan. "We have seen a lot of growth in that area."

Since the agency has had difficulty finding enough qualified individuals to hire, individuals were given the option of hiring their own. To help them do so, a direct care worker registry was developed, with names listed on an electronic registry for participants to access.

"People may need hands-on care. They have to be able to access someone to help. At the same time, we are also working closely with nursing homes. There will always be a need for nursing home care," says Mr. Hogan. "We are trying to work as hard as we can to balance both sides of the system."

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Zero in on cost containment for kids with chronic conditions

Just 10% of enrollees, two-thirds of whom have a chronic condition, account for 72% of spending on children in Medicaid and the Children's Health Insurance Program (CHIP), according to a study published by **Genevieve M. Kenney**, PhD, Thomas Selden, and Joel Ruhter in *Health Affairs*, "Containing Costs And Improving Care For Children In Medicaid And CHIP."

These data highlight the importance of cost-containment strategies to reduce avoidable hospitalizations and emergency department (ED) use among children with chronic problems, and policies that increase preventive care, particularly among African-American children.

"We were only able to look at this at a national level, but it made me think about how critical it is to understand the state variation in this. We just don't have our arms wrapped around that right now," says Kenney, the study's lead author and a senior fellow and health economist at The Urban Institute in Washington, DC.

However, since state claims data also reflect high levels of concentration in spending for children, "that suggests that this is probably the norm," says Dr. Kenney.

The researchers expected to find higher spending levels for disabled children who qualify for Supplemental Security Income (SSI), which are high-need populations. That pattern was borne out in the data. Surprisingly, though, the spending distribution was heavily concentrated among Medicaid and CHIP-enrolled kids who were *not* enrolled in SSI as well.

High spenders were more likely to have ED visits and hospital stays. This might be due to higher need for this type of care, but it also might reflect some inefficiencies in the delivery of care. If that is the case, then cost savings could be seen if outpatient care is managed more effectively.

"What feels highly actionable to me, from a policy standpoint, are the findings that indicate that such a high share of the kids in the upper part of the spending distribution have chronic health problems, and that high levels of spending frequently persist over time," says Dr. Kenney. "What that suggests is that states could achieve higher-quality, lower-cost care by testing and evaluating care coordination and disease management programs and other service delivery strategies targeted to children with chronic health problems. It could [prove] fruitful for Medicaid programs to zero in on this population, particularly the children who qualify for SSI."

Some getting no care

On the other end of the spectrum, 30% of the enrolled children received little or no care at all. "We were struck by the low spending side as another area that would require a different set of responses," says Kenney. "States should look closely at the children who are enrolled for a whole year who aren't showing up as getting any services. This could indicate problems with accessing care. Not seeing providers could also mean that children's health problems aren't being diagnosed."

In addition, for children who *are* receiving health care, it's not clear that they are getting the recommended levels of care, or that the care they are getting is appropriate.

"We know that health-seeking behavior and patterns of care are influenced both by provider availability and the individual's perception of their care needs," says Dr. Kenney. "Even for kids with private coverage, there can be low spenders. This type of issue isn't unique to public programs. But given that Medicaid and CHIP disproportionately serve children with more health problems and minority backgrounds, there is additional reason to worry about it."

Potential for savings

Cost-containment programs in Medicaid are largely focused on adults, partly because spending levels are higher than for children on average. "The concentration of high spenders in adults has been documented and explored, and now the same pattern is playing out with kids," says Dr. Kenney.

Dr. Kenney says it's "probably a safe bet that a big chunk of spending on children in any state's Medicaid program" is concentrated among the kids either enrolled in SSI or who have chronic health care problems.

For this reason, she says states would do well to develop strategies to identify children with chronic health care problems who are *not* enrolled in SSI. "When a child enrolls in Medicaid or CHIP, it's rare for them to fill out a health survey that indicates any conditions they might have," says Dr. Kenney. "States would also want to look at service patterns to see if there are certain models that are both lower cost and achieve better outcomes." For example, some care delivery models may have lower rates of ED use for kids or fewer hospitalizations for avoidable conditions.

"There will always be kids with large spending levels due to unexpected illnesses or accidents, but the persistence of high spending among children with chronic health care problems suggests that targeting them could pay off," says Dr. Kenney.

The tendency for children to "churn" in and out of Medicaid and

CHIP is one complicating factor. If a child's asthma is managed more effectively, and this prevents an ED visit or hospitalization in the short term, the Medicaid program will see the savings. However, this is not the case if the ED visit is avoided after the child switches to private coverage. "We have to think about this from a more global perspective," says Dr. Kenney.

Since kids in SSI-eligible categories have high spending levels and because they are likely to have more continuous enrollment relative to other groups of children, this may be a good population to start with. "We are seeing that the burden of chronic illness is increasing with children. Moving forward, this will become an even more important issue facing state Medicaid and CHIP programs," says Dr. Kenney.

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Program targets high-cost, high-risk Medicaid clients

In Oklahoma, a health management program targets high-cost and/or high-utilization Medicaid clients, both adults and children. "Through predictive modeling, we identify our members, adults and children, at risk for higher costs or utilization. If they are within the targeted top 5,000 at highest risk and agree to participate, we enroll them in our health management program," says **Marlene Asmussen**, RN, director of SoonerCare Medicaid care management and health management.

The first tier of the health management program is limited to the top 1,000 members at risk for the highest utilization or costs. A contracted vendor's nurse care managers attempt an in-person meeting with these individuals on a monthly basis or as needed. The visit covers all aspects of self-management, including the importance of taking medications as prescribed, adherence to their prescribed medical regimen and scheduling, and keeping all medical appointments. A second tier of the health management program captures the next 4,000 members who are also at risk for high cost and/or high utilization. These members receive a monthly telephone consult from the contracted vendor's nurse care managers.

"This program is still very young, but the first indication is that there are some cost savings with the more intensive Tier 1 intervention related to hospitalizations and ER use. We are not seeing the same level of impact with the Tier 2," says Ms. Asmussen.

The program came about as a result of a legislative mandate and is limited to an enrollment of 5,000. "We are not quite at the 5,000 mark, but we may limit the program to our current enrollment due to budgetary concerns," says Ms. Asmussen. "Tier 1 of the health management program is a resource-intensive intervention, but it has certainly been beneficial for the member at risk for high cost/high utilization, and for the program."

Another initiative involves a community-based, multiagency effort for reaching out to support children with special health care needs. "This is funded through a variety of mechanisms," says **Terrie Fritz**, director of SoonerCare's Child Health Unit. "It is about SoonerCare Medicaid benefits, but also all of their other needs as well."

The agency has made a lot of effort to get input from consumers in order to better meet the needs of members. "Currently, we have a child health and a perinatal advisory task force with consumers on those," says Ms. Fritz. "We are also committed to launching a Consumer Advisory Task Force this year."

That Task Force is expected to answer many questions about how the program can better reach members. "As the director of child health, I will be focused on, 'How can we get you to use early intervention services and early prenatal care?'" says Ms. Fritz. "I'll be using this forum to develop ideas around better utilization of benefits, and also how we can structure services to do a better job of serving children."

As the next round of budget cuts approaches, consumers will be asked for their advice on this as well. "For the first round, we have had to cut some services and realign some benefits. We reconfigured some things, but the biggest brunt of the changes did not involve children," says Ms. Fritz. "There were some changes to behavioral health that do impact children, but for the most part, because of the stimulus money, we didn't really have to cut out benefits at this point. But those still can be on the chopping block for the next round."

Some of the suggestions made by providers on the perinatal and child health advisory task forces were implemented. For instance, there was a resounding response that if provider cuts were needed, these should be made across the board. "While I may favor child health, if we cut the specialty care, that's just as important. They told us that however deep you need to go, whether 1% or 2%, do it all the same," says Ms. Fritz.

Other suggestions were to cut coverage for dental composite, so that composite fillings for back teeth for children are no longer covered, and are instead paid for at the amalgam rate, and decreased payments for cesareans to eliminate incentives for doing these instead of vaginal

deliveries. "We are trying to find strategies to improve the care overall, and get us in a direction we might have wanted to go anyway. It's a little less painful that way," says Ms. Fritz.

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Medicaid faces obstacles to integrating care for duals

Integrating care for dual-eligibles clearly presents many opportunities for state Medicaid programs. Unfortunately, progress has been slow, according to The Commonwealth Fund's November 2009 policy brief "Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options."

One of the biggest challenges, according to **Sara Rosenbaum**, JD, one of the brief's authors and chair of the Department of Health Policy at the School of Public Health and Health Services at The George Washington University Medical Center in Washington, DC, is "the development of provider capacity to act as medical homes, and eventually, accountable care organizations, for the population."

Another major challenge, as noted in the brief, is developing integrated financing arrangements with Medicare. This way, bundled payments, medical homes, and gain-sharing models can be put to work across the two programs.

MN first with dual-eligibles

Minnesota was the first state to establish integrated programs for dual-eligibles, starting with a Medicare demonstration approved by the Centers for Medicare & Medicaid Services (CMS) in 1995. "We have continued to build on that early demonstration. We now have statewide coverage for two integrated programs for dually eligible seniors and people with disabilities," reports **Brian Osberg**, Minnesota state Medicaid director.

The state contracts with 14 Medicare Advantage Special Needs Plans (SNPs) to provide integrated Medicare and Medicaid services for dual-eligibles in two special programs, both of which operate in all 87 counties in Minnesota. Enrollment in these programs is voluntary.

Minnesota Senior Health Options, the first and largest program, operating since 1997, serves about 37,000 seniors under contracts with eight SNPs. This group comprises about 70% of all dually eligible seniors in the state. The SNPs provide all Medicare and Medicaid services, including behavioral health, long-term care, and home- and community-based services.

Special Needs Basic Care, which began in 2008, has now enrolled about 4,000 people with disabilities ages 18 to 64 under contracts with six SNPs. This program doesn't include home- and community-based services, but it does cover extensive behavioral and mental health services. "It serves as a platform for a special mental health initiative designed to improve coordination of physical and mental health," says Mr. Osberg.

Minnesota has worked with the SNPs to implement numerous administrative processes designed to integrate enrollment, member materials, and coverage decisions. This includes Part D Medicare drugs, networks, care coordination, access to health care homes, and oversight and reporting requirements. The goal is to simplify and streamline access to care for dual-eligibles.

For example, enrollees sign a single enrollment form and receive a single set of materials that explains all benefits under Medicare and Medicaid. Each member has a personal care coordinator or a health care navigator to assist them with appropriate care and services.

National policy lacking

"Our biggest challenge has been lack of a clear and consistent policy at the national level that supports the integration and coordination of care for dual-eligibles on a permanent basis," says Mr. Osberg.

Mr. Osberg says, however, that over the years, CMS support for integration of care for dual-eligibles has expanded. "They have been very supportive of our efforts to integrate care under SNP contracts. However, more clarity about the future viability of SNPs under Medicare Advantage financing, more flexibility to align operational policy between Medicare

and Medicaid, and additional resources for assisting states and SNPs to accomplish integration are needed to provide a stable platform for continued integration," he says.

In addition, most state efforts to improve care under integrated models will provide more immediate savings to Medicare. There is currently no mechanism for states to share directly in that savings. "Until these issues are addressed, many states will find it difficult to implement such integrated programs," says Mr. Osberg.

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Reduce ED wait with lean management

Lean management techniques helped Lahey Clinic Medical Center, North Shore, in the city of Peabody, MA, boost patient satisfaction and reduce emergency department (ED) waiting times.

Lahey is a full-service hospital featuring a 24-hour ED, the only ED in Peabody. More than 17,000 patients visit the ED annually. In October 2007, Lahey partnered with an Ottumwa, IA-based consulting firm to coach hospital staff on the application of lean management skills by revisiting their processes in the emergency department and identifying more efficiencies to improve patient care.

The first problem identified was the increased volume of ED visits, which resulted in long wait times for patients, says **Bob Schneider**, senior vice president at the hospital. With the goal of preserving patient care, Lahey began a series of rapid improvement events to help physicians, nurses, and staff see work more efficiently in their daily tasks. Mr. Schneider says the goal was to improve patient flow and reduce waiting time. Facilitators led selected members of the hospital and patients in an intensive forum where new ideas for improvement were piloted.

When Lahey decided to pursue lean management practices in the ED, the organization had a particular interest in better serving patients not deemed in critical, urgent need of assistance, Mr. Schneider explains.

Lahey developed new roles and work processes that addressed those issues and significantly reduced the wait time for all patients. First, Lahey added the role of "air traffic controller" jointly managed by the unit secretary and charge nurse with help from the triage nurses. It is now their responsibility to help monitor patient flow throughout the department and to match available physicians with patients who have been waiting long periods of time and match them up accordingly, Mr. Schneider explains. ■