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In This Issue

Drug rebates mean immediate fiscal relief for some Medicaid programs

Much of the hotly debated health care reform legislation won't actually be implemented for months or years, but an expanded drug rebate program is an important exception. States can collect additional rebates right away, which may help some with severe budget shortfalls. The rebates are only for drugs prescribed to enrollees of Medicaid managed care plans, though, so states without managed care won't see any savings.

"The drug rebate savings are effective as of the date of enactment," says **Margaret A. Murray**, chief executive officer of the Association for Community Affiliated Plans in Washington, DC, which represents nonprofit Medicaid managed care health plans.

"For those plans that currently have managed care programs, this is one of the few places they will immediately see savings from health care reform," says Ms. Murray. "There is some work to do on getting the data from the plans about the drugs they have paid for, but these are immediate savings for this fiscal year."

Previously, drug rebates had been restricted to Medicaid beneficiaries in fee-for-service programs. "This is a major improvement and long-overdue correction," says Ms. Murray.

*See **Drug Rebates** on page 2*

Rhode Island expects to benefit from rebate program

Like many state Medicaid directors, **Elena Nicolella** says that her biggest fiscal challenge is responding to an ever-increasing need for services with an ever-decreasing amount of revenue.

While the full fiscal impact of the drug rebate program included in the health care reform law isn't yet clear, Ms. Nicolella says that Rhode Island will benefit from the application of the rebate to drugs purchased through Medicaid managed care arrangements. "We will need to work closely with our Medicaid managed care organizations to ensure we are collecting the data that is required," says Ms. Nicolella.

However, there is an important caveat. "The benefits of that change will certainly be offset by any decreases we experience in our current supplemental agreements," says Ms. Nicolella. "We have initially estimated those losses to be at around 30%."

Fiscal Fitness: How States Cope

Ms. Nicolella adds, "We are fortunate that we adopted Medicaid managed care as a delivery system. If we had not, we would not

*See **Fiscal Fitness** on page 4*

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Editor: **Stacey Kusterbeck**, (631) 425-9760, staceykusterbeck@aol.com.
Managing Editor: **Karen Young**, (404) 262-5423, karen.young@ahcmedia.com.
Executive Editor:
Russ Underwood, (404) 262-5521, russ.underwood@ahcmedia.com.
Production Editor:
Ami Sutaria.
Director of Marketing:
Schandale Kornegay.

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Cover story

Continued from page 1

"For states, it will mean substantial savings on prescription drugs. This will help them deal with their tight budgets and allow them to make more rational decisions about their Medicaid programs."

The Medicaid discount provisions are based on the Drug Rebate Equalization Act legislation. However, states that don't have any managed care won't see any savings. "In fact, many of them will see losses, due to the recapture of the drug rebate above 15% and below 23%," says Ms. Murray.

Minnesota's Department of Human Services will collect rebates for drugs dispensed to managed care enrollees dating back to March 23, 2010. "We'll begin the process by working with managed care plans to get data on drugs dispensed, so we can calculate and collect the rebates," says **Brian Osberg**, state Medicaid director. "We are expecting additional guidance from [the Centers for Medicare & Medicaid Services] in the coming weeks, as we move toward full implementation of this new requirement."

It is too soon to accurately evaluate the fiscal impact this legislation will have for Minnesota's Medicaid program. "We do not yet know if adjustments will need to be made to the capitation rate paid to the managed care organizations," says Mr. Osberg. "We also do not yet know how the new rebate calculations will impact rebate amounts." There is no expectation of being able to collect supplemental rebates on drugs dispensed to managed care enrollees, however. "So, we anticipate that the average rebate per prescription will be lower than what the state receives for drugs dispensed by fee-for-service," says Mr. Osberg. "More detailed data sharing will need to occur between the managed care plans and the state Medicaid agency."

Fiscal impact varies

There are currently 23 states using a carve-in approach, with pharmacy benefits included in capitated contracts. These states should realize "a large and immediate savings from the bill" for prescriptions received by Medicaid managed care health plan enrollees, according to **Joel Menges**, a managing director at The Lewin Group in Falls Church, VA.

A September 2008 report from The Lewin Group, *Analysis of Drug Rebate Equalization Act's Savings to the Medicaid Program*, estimated a total Medicaid savings of $12.6 billion over five years from 2009-2013. Since the health reform bill was passed, The Lewin Group has worked with several states to evaluate the financial impact of the specific provisions of the bill.

As for the large federal Medicaid fee-for-service rebates, which have been extended to medications purchased by Medicaid health plans effective as of March 23, 2010, these "often represent more than 30% of the initial amount paid to the pharmacies," says Mr. Menges. "However, in the 13 states now using a carve-out approach, the rebate equalization provisions of the bill will create little immediate fiscal impact on their state budgets, since the large rebates are already being accessed."

While the reform bill also raises the federally mandated minimum rebate levels for prescriptions filled under fee-for-service, the federal government receives 100% of these additional rebates. "Thus, those provisions should have little or no immediate impact on states' fee-for-service budgets," says Mr. Menges.

However, drug manufacturers may negotiate smaller supplemental rebates than are currently in use

to offset some of the revenue losses they are experiencing from the bill's Medicaid rebate provisions. For this reason, several states may experience a net additional cost on the medications they are purchasing via their fee-for-service program.

"It is not currently clear whether, or by how much, supplemental rebates will be reduced, as these will be negotiated outcomes between states and the drug manufacturers," says Mr. Menges.

Switch to carve-in?

Previously, Medicaid agencies could either access the best management of the benefit through a "carve-in" approach or the best unit price via a "carve-out" approach, but not both. They were forced to make an "unwelcome choice" between these two options, says Mr. Menges.

"The rebate equalization provisions across fee-for-service and managed care are a significant help to states," says Mr. Menges. "Now, states have access to the strongest pharmacy benefits management and the lowest unit prices, simultaneously."

Equalizing the rebate program removes the incentive to carve out drug benefits, since the states that currently carve drugs out of their capitation won't see savings from the program. For this reason, Ms. Murray says she expects that over time, "many of those states will start to think about carving the drugs back in."

In addition to the savings, carving drugs in allows health plans to access information on the medications a patient is taking. "This means that better care is provided, because health plans can manage the whole person," says Ms. Murray. "They know who's pregnant, because they see someone is on prenatal vitamins. They know who has asthma or who is HIV-positive because of the drugs they are taking. So, they are able to coordinate their care of those populations."

Assuming the 13 states currently carving out the drug benefit do switch to a carve-in approach, Mr. Menges says that costs are likely to decrease due to an increased use of generics and lower-cost brand medications. A decrease in the overall usage rate of prescriptions is also likely. "The at-risk health plans have been shown to achieve a more cost-effective volume and mix of medications than has occurred in the Medicaid fee-for-service setting," says Mr. Menges.

Rebate is shared

Rachel L. Garfield, PhD, an assistant professor in the Department of Health Policy and Management at the University of Pittsburgh's Graduate School of Public Health, says, however, "There are two factors at play here, possibly working in different directions."

One issue concerns how the rebate is shared between states and the federal government. In the past, rebates covered under the agreement with the federal government were split between states and the federal government, according to the state's FMAP.

The new law increases the minimum rebate percentage, but it says that rebate dollars attributed to that increase will go entirely to the federal government. "This means that states will not see funds from the increase in the minimum rebate percentage," says Dr. Garfield.

Further, most states negotiate with drug manufacturers for supplemental rebates in addition to those covered under the agreement with the federal government. "Rebates in many states are already above the new federal minimum rebate percentage," says Dr. Garfield. "Under the law, it appears that these states will lose their share of the rebate between the old and new federal minimum percentage."

Therefore, states are concerned that this provision will lead to a substantial shift in rebate dollars from states to the federal government.

The other factor is related to the extension of the rebate program to drugs covered under agreement with managed care companies. In the past, prescription drugs that were covered under state contracts with Medicaid managed care companies were not eligible for rebates under the federal Medicaid rebate program.

In some states, including Pennsylvania, there was concern that this restriction led the state to lose out on potentially large rebates. "Some states made the decision to exclude prescription drugs from contracts with Medicaid managed care companies in order to claim the drug rebates," says Dr. Garfield.

However, this arrangement was not ideal. Managed care companies have more tools to manage utilization, resulting in lower drug costs, and are able to use prescription drug utilization data for case management.

Since the new law extends the Medicaid rebate program to managed care, states that included prescription drugs in their managed care contracts will see increased rebate dollars. "In addition, states that had made the policy choice to exclude prescription drugs from managed care contracts may revisit this decision and include drugs in the contracts," says Dr. Garfield. "Thus, they will gain the advantages of both the rebate dollars and the care management tools available under managed care."

Contact Dr. Garfield at (412) 383-7279 or rachelg@pitt.edu, Mr. Menges at (703) 269-5598 or joel.menges@Lewin.com, Ms. Murray at (202) 204-7509 or MMurray@communityplans.net. and Mr. Osberg at Brian.Osberg@state.mn.us or (651) 431-2189. ■

Fiscal Fitness

Continued from page 1

experience any benefit from these changes."

The long-term impact of the rebate program on Rhode Island Medicaid, however, remains unclear. "We will always have a portion of our population for whom we are purchasing drugs directly," explains Ms. Nicolella. "The expanded drug rebate program essentially limits our ability to negotiate rebates above levels in existence before passage of the Affordable Care Act."

Since the majority of the population enrolls in a managed care delivery system, though, Rhode Island does expect to be among those states that see a fiscal benefit. "We will have to monitor how the drug manufacturers react to the new requirements," says Ms. Nicolella. "We may have to spend more time on dispute resolution."

Data will be integrated

"We are very excited about the recent roll-out of our data warehouse, CHOICES," says Ms. Nicolella. "Unfortunately, the recent floods in Rhode Island have delayed our ability to fully roll out in the time frame we had hoped."

Once it is fully operational, however, Rhode Island Medicaid will be able to quickly combine eligibility, claims, and utilization data from multiple state agencies. "This will allow us to evaluate all of our publicly funded programs from a more comprehensive perspective," says Ms. Nicolella. "This will enable us to understand the impact of Medicaid on state-only spending, and vice-versa."

Individual client data will be accessible from multiple programs across state agencies. This will improve coordination of health and human services programs, especially those funded by Medicaid.

The system also has a specific predictive cost-modeling component that can identify high utilizers, which should be operational within a year. This will improve the state's ability to forecast expenses and predict potentially high-cost cases. "Initially, we will be able to develop reports that identify high-cost cases or high utilizers based on indicators we use now," says Ms. Nicolella. "CHOICES will enable us to produce these reports quickly. It will also allow us to use data outside of the Medicaid program." This means that individuals can be identified who may not be utilizing services funded by one state agency at all, but may be over-utilizing services funded by a different state agency.

Other initiatives under way

Four other major initiatives will be implemented by Rhode Island Medicaid during fiscal year 2011. The first two involve reforming the way hospital and nursing home services are paid for. First, an acuity-adjusted rate for nursing homes will be implemented in July 2011. An APR-DRG payment system for inpatient hospital services is also being implemented.

"We intend these two payment reform initiatives to result in payments more closely aligned with the needs of Medicaid beneficiaries," says Ms. Nicolella. "These initiatives also seek to increase the transparency of how Medicaid pays for services."

Thirdly, Medicaid managed care contracts are being re-procured. As part of this initiative, the state is seeking to combine its two large separate managed care programs, one for children and families, and one for adults with disabilities, into a single program.

Lastly, Rhode Island Medicaid is setting out to improve the connection of its long-term care system to primary and acute care services. This will be based on the concepts of the primary care medical home.

"This initiative will seek to decrease the isolation that individuals and families can experience as they transition from setting to setting, from hospital to nursing home back to home," says Ms. Nicolella. "We want to ensure that care is coordinated through these transitions and that primary care practices are engaged."

Ongoing HIE efforts

Coming up with the necessary funding to implement health information technology, even with federal incentives, is one current challenge. "Even in good times, the 10% state match is frequently a limiting factor. It is especially hard to obtain the monies in hard times," says Ms. Nicolella.

The state work force head count has decreased due to an employee attrition program. This has led to an increased work load on the people remaining in Rhode Island Medicaid.

"Therefore, the Medicaid program must thoughtfully plan how to maintain the 10-year Electronic Health Records incentive program, by staffing it with personnel who have the requisite expertise to maximize implementation statewide," says Ms. Nicolella.

Rhode Island's small size means that there will be only one Health Information Exchange (HIE) statewide. "So, our medium- and long-term concerns of HIE interoperability are more interstate rather than intrastate," says Ms. Nicolella. "We recognize that implementing our HIE statewide will take considerable time and effort by us and many other parties in Rhode Island."

Rhode Island Medicaid is also working on modernizing its IT systems to the Centers for Medicare & Medicaid Services (CMS)' Medicaid Information Technology Architecture specifications.

"This has large implications for our integration with the state HIE and data exchange in general," says Ms. Nicolella. "We also have the challenge of devising a logical way to make the central HIE integrate with other systems." For example, the large hospital networks have Internet-based systems that extend to multiple providers.

Rhode Island's HIE efforts have been ongoing for several years, with the first implementation completed in the first half of 2010. As the regional health information organization and the Regional Extension Center for the state, the Rhode Island Quality Institute in Providence will play a major role in seeing the process through, along with the Medicaid agency and the Department of Health.

"The multiyear efforts mean stakeholders are well informed of the issues and have an awareness of the key players in Rhode Island," says Ms. Nicolella. "This core group of people will be called upon again to take the implementation to the next stage."

Ms. Nicolella says that CMS' proposed definition of "meaningful use" "appeared logical and well thought out, although the requirements are daunting. It starts out providers and hospitals with a relatively low qualification bar for Stage 1 that ratchets up to more stringent requirements in the ensuing years."

Ms. Nicolella says that at this stage, she expected more software vendors of electronic health records (EHRs) to be ready to meet CMS' requirements for Stages 2 and 3 of implementation. "However, we expect the EHR software companies will rise to the challenge, so the providers and hospitals will have a good range of choices when it comes time to buy," she says. "As to helping the providers qualify for incentives, Medicaid and the Rhode Island Quality Institute will collaborate to produce education tailored to assist the providers and hospitals."

[Contact Ms. Nicolella at ENicolella @dhs.ri.gov.] ■

Rebates are net gain for some states, but outlay of funds needed to increase necessary staffing

Athos Alexandrou, director of Maryland's Medicaid pharmacy program, says the state will benefit fiscally from the health care reform legislation's drug rebate program, by getting a share of rebates for pharmaceuticals dispensed by managed care organizations (MCOs). On the other hand, money will be lost on the fee-for-service side.

"The federal government will be taking a larger share of those rebates," says Mr. Alexandrou. "But the net should be some additional savings to the state. We are expecting to see an increase in state revenues due to the additional rebates."

However, system changes and additional staffing clearly will be necessary to take advantage of that. In addition, the state's drug rebate vendor will need to implement its own system changes and increase staffing, in order to accommodate the increase in rebate billings and revenues for those patients enrolled in MCOs.

"Furthermore, the department will have to hire additional staff necessary to handle the increase in rebate billings and disputes," says Mr. Alexandrou. The MCOs may have to provide the department with additional claims data and reports necessary to handle rebate billing and disputes from the drug manufacturers, as well.

Ralph Magrish, Medicaid Pharmacy Program Manager for Oregon's Department of Human Services, says that the agency will be required to spend "unplanned and unbudgeted funds." This will be necessary in order to configure systems and processes within its Medicaid Management Information System, to collect rebates on MCO claims, and require changes to the agency's accounting systems.

"The agency may need to amend contracts with MCO plans to adjust capitated rates accordingly," adds Mr. Magrish. Additionally, the agency will need to promulgate new administrative rules for the managed care plans to follow. These will detail how claims and encounter data will be provided to the state.

The state is awaiting further clarification from the Centers for Medicare & Medicaid Services on the intersection between prescriptions for members of Medicaid MCOs filled by 340b pharmacies, which are exempt from rebates. This may lead to the need for further system modifications and re-evaluation of actuarial rates.

One immediate benefit is savings resulting from the consolidation of purchasing drugs for the entire Oregon Medicaid population. "The state is anticipating that it will be entitled to keep all supplemental rebates it negotiates with manufacturers for preferred products in the fee-for-service population," says Mr. Magrish. "This is a change from current requirements where the state shares a portion with the federal government. It will encourage the state to negotiate more aggressively with manufacturers."

However, more staffing will be required to invoice, audit, and handle disputes for the rebate program. Whether it's done by state personnel or a contractor, this will require additional expenditures by the state. "It will require an outlay of funds to configure systems and processes to collect rebates on MCO claims and capturing of utilization data for drug rebate invoicing, including physician-administered drugs," says Mr. Magrish.

Contact Mr. Alexandrou at (410) 767-1455 or AlexandrouA@dhmh.state.md.us and Mr. Magrish at (503) 945-9691 or Ralph.M.Magrish@state.or.us. ■

Health care reform paves way for managed care

Medicaid managed care plans currently serve 21.6 million people, and this number is expected to increase significantly as a result of the health care reform legislation. One reason is newly available drug rebates. "This is just one more reason that states might want to put more people into managed care," says **Margaret A. Murray**, chief executive officer of the Association for Community Affiliated Plans in Washington, DC, which represents nonprofit Medicaid managed care health plans.

"States that want to do the expansion early will have to do that under the regular FMAP. So, they will be looking for savings." For this reason, Ms. Murray says she expects states to look at moving additional populations into managed care, despite certain obstacles.

"Change is frightening for people, so that is one issue," says Ms. Murray. "Secondly, health plans can't always negotiate better rates in rural areas, because there is only one provider to begin with. So managed care has typically not been as prevalent in rural areas, both in Medicaid and the commercial world."

With dual-eligibles, states are only responsible for a small part of their overall health costs. "So, in some cases, states have been reluctant to put their duals in," says Ms. Murray. "But we've been seeing every year that more states [are] putting more populations into managed care. That is definitely the trend."

The drug rebate program and resulting managed care expansion is a "win-win" for the states, the health plans, and the beneficiaries, according to Ms. Murray. Whereas states don't always measure the quality of fee-for-service programs, managed care programs must meet quality metrics to avoid penalties.

"There are access provisions for the networks that they have to meet," says Ms. Murray. "States hold their Medicaid managed care programs to a much higher standard than their fee-for-service programs. The preponderance of evidence shows that the quality of managed care is better."

Most of the estimated 16 million people coming onto Medicaid are expected to go into Medicaid managed care. "That is certainly what we saw with the Children's Health Insurance Program. Most of those kids are in managed care today," says Ms. Murray.

In 1990, only 9% of Medicaid enrollees were in managed care. Today, more than 70% are enrolled in managed care. "We believe the growth of Medicaid managed care programs will be substantial," says **Thomas L. Johnson**, president and CEO, Medicaid Health Plans of America in Washington, DC. "States were already finding value with the coordinated care provided by Medicaid health plans. This will only increase with the new health care law."

Mr. Johnson notes that significant Medicaid managed care expansion is already under way, pointing to examples in several states. Florida, for example, is currently considering implementing statewide Medicaid managed care using fully capitated at-risk health plans, expanding the current five-county pilot there.

"Texas currently has an RFP out for 13 new counties in the Dallas area, and Illinois will issue a new RFP in the next two months for their aged, blind, and disabled population," says Mr. Johnson. Louisiana wants to use health plans to create a coordinated care delivery system in Medicaid and has submitted a waiver to the Centers for Medicare & Medicaid Services for approval.

"The overwhelming factors right now are state budget shortfalls and escalating health care costs," says Mr. Johnson. "Medicaid health plans offer predictable costs, higher quality care, and better outcomes than traditional Medicaid. This makes managed care programs a better value for states."

Medicaid health plans are looking at new cost-containment strategies and care delivery models to help control entitlement spending. "There is substantial potential for savings by looking at what managed care can do for the dual-eligible, senior, and disabled populations," says Mr. Johnson. "I would expect states to explore managed care expansions in these areas."

Contact Mr. Johnson at (202) 364-8134 or tjohnson@mhpa.org. ■

Medicaid programs may act now on childless adults

As of 2014, Medicaid will cover everyone below 133% of the federal poverty level, including childless adults and others who are currently ineligible. However, the new health care reform law gives states the option of covering additional low-income adults right away.

Previously, states had to seek a Medicaid waiver to provide this coverage and were required to show that expanding coverage would not increase federal expenditures in the state.

However, states that already cover childless adults through a state-funded program are the ones most likely to consider this new option, according to **January Angeles**, a policy analyst at the Center on Budget and Policy Priorities in Washington, DC. These include Washington, Connecticut, Minnesota, and Pennsylvania.

"If they take the option to move those childless adults into Medicaid, then they would get a federal match for that, whereas if they keep their current program, it's all being paid for through state funds," says Ms. Angeles. "So, that is the attraction there."

Since states that don't cover any childless adults now will get the enhanced FMAP for all their childless adults, they would clearly get a larger population of their Medicaid expansion covered through federal dollars. States that want to start covering childless adults before 2014 don't necessarily need to expand all the way up to 133% of the FPL, however.

"You can phase in the expansion and set lower income thresholds, such as 50% or 75% of the poverty line. But within that income range, you can't cap enrollment," says Ms. Angeles. "So, if states expand to 100% of the poverty line, that means anybody with an income up to that level who applies and qualifies would have to be covered."

Some state-only programs currently have enrollment caps. If they reach a certain enrollment number, they start to form a waiting list. A state-only program may cover up to 200% of the FPL with a cap of 20,000 for enrollment, for instance.

"There is no way to say for sure that the amount of money you have appropriated for this program is what you are going to spend in Medicaid if you choose the early expansion. In Medicaid, you can't stop enrollment when you hit a certain level of spending," says Ms. Angeles.

For this reason, states may choose to slowly phase in the expansion, such as starting at 25% or 50% of the poverty line. This would reduce the likelihood of states "not being able to contribute the state match to keep the early Medicaid expansion running," says Ms. Angeles.

Other considerations

According to a guidance from the Centers for Medicare & Medicaid Services on coverage for the newly eligible population, states are required to provide these individuals with a benchmark benefits package. This doesn't necessarily mean a traditional Medicaid benefits package.

"There is a lot of flexibility to define what that benefit package would be," says Ms. Angeles. "So, the level of benefits to provide is another consideration for states that do expand, because they are not required to provide the full Medicaid package."

In light of the new subsidies and the Medicaid expansion that will both come on board in 2014, there will be a need to coordinate these two systems. "That is an issue that all states will have to grapple with," says Ms. Angeles. "Another consideration is a change in the income definition for Medicaid to align with the subsidies."

States will also need to think about how to change, modify, or improve their eligibility system in order to anticipate both the Medicaid expansion and the subsidies that are going to be available by 2014. For example, there is a requirement in the health care reform legislation for a single application and a streamlined process.

"Changes will have to be made to the current Medicaid eligibility process. States will have to start thinking about implementing that ahead of the coverage expansion," says Ms. Angeles. "Some eligibility systems are really archaic and difficult to change. A slight change can require [a] significant amount of time or resources to implement."

If states have already simplified some of those rules and procedures, though, they won't have to do as much to get ready for health reform. For example, health reform would eliminate asset tests for Medicaid. "Some states have already done that for all their kids and parents, so that is one less thing that they will have to do," says Ms. Angeles.

Preparing for changes

Maine's Medicaid program now covers childless adults to 100% of the FPL through a capped waiver. "The cap is a fiscal cap. Currently, we have about 12,000 people covered," says **Trish Riley**, director of the governor's office of health policy and finance.

Ms. Riley adds that Maine's Medicaid program is "well positioned for reform." With federal financial support at 100% for start up, then at 90% later, we think the plan is affordable for Maine," says

Ms. Riley. "There are potential savings to the state," explains Ms. Riley. "If we retain children in CHIP, we receive a 23-point increase in federal match. We now cover about 15,000 children in CHIP but have not calculated savings yet." The state also will see reduced Medicaid costs that now pay for parents to 200% FPL, when those parents convert to subsidized coverage.

In Iowa, childless adults are covered by IowaCare, a waiver program that was created five years ago in the wake of the intergovernmental transfer business. Coverage is limited and, because of the funding mechanism, people must receive care only at University of Iowa Hospitals in Iowa City or, if they live in Polk County, at the public hospital in Des Moines.

Current enrollment is about 400,000. "We expect that in three years, when health care reform kicks in, there will be demand from an additional 80,000 to 100,000 people, mostly singles and childless adults," says **Jennifer Vermeer**, Iowa's Medicaid director. "The challenge here is similar to the challenge elsewhere — how to build up the provider network, how to revamp the eligibility system, and how to pay for the state's share."

Contact Ms. Angeles at (202) 408-1080 or angeles@cbpp.org, Ms. Riley at (207) 624-7442 or Trish.Riley@maine.gov, and Ms. Vermeer at (515) 725-1123 or jvermee@dhs.state.ia.us. ■

Signs of improved access to Medicaid providers

With an estimated 16 million additional Americans coming onto the Medicaid program as of 2014, having enough providers to ensure good access to care is certainly a legitimate concern. However, **Judy Solomon**, a senior fellow specializing in Medicaid and the Children's Health Insurance Program at the Washington, DC-based Center on Budget and Policy Priorities, says that "a couple of things raise my hopes."

First, reimbursement for certain primary care services will be increased to Medicare rates. This will be fully funded by the federal government. "Hopefully that will set the stage for having more provider participation," says Ms. Solomon. "Since that kicks in in 2013, the hope is that provider panels will be expanded in advance of 2014."

Secondly, there are substantial increases in funding for community health centers, both in the stimulus package and the health reform legislation. "That will help them to expand and do some of the brick and mortar work needed to increase capacity," says Ms. Solomon.

Impact of provider cuts

Interestingly, despite some significant provider rate cuts, many Medicaid programs are not seeing marked increases of problems with their beneficiaries accessing care. Ms. Solomon says this is likely due to the type of providers who received cuts. "My sense is that states tend to look at institutional providers like hospitals and nursing homes, and sometimes home health," she says.

Instead of making cuts to rates of primary care providers, states were more likely to eliminate optional services altogether, such as dental coverage for adults. "A number of states have done this rather than cut the rates. The reason for that is there is not much margin to begin with. There is just not much money to be saved there," says Ms. Solomon. "You can only go so low."

While fewer people use hospital and nursing home care, these services are more costly, so states saw an opportunity for substantial savings. "Since they are more expensive, states tend to go there. Also, they don't foresee an access problem arising from cutting those services, certainly not on the hospital side," says Ms. Solomon.

For instance, when the governor of Tennessee proposed capping hospital payments at $10,000 earlier this year, "I don't think anyone thought that hospitals would throw people out when the cash register totaled $10,000. I think the assumption of hospitals was that this would represent a shift to uncompensated care," says Ms. Solomon.

The Center on Budget and Policy Priorities has been monitoring the impact of cuts made to Medicaid programs throughout the recession, such as the elimination of dental services. As for difficulties in accessing care, however, Solomon says that "I don't think anybody is systematically monitoring this."

Some states do secret shopper surveys as part of the oversight of their Medicaid managed care programs. This may include attempting to get timely appointments with providers. With fee-for-service programs, though, access to care isn't specifically tracked.

"There was a lot of pushback on expansion of Medicaid from people who asked why would we be expanding Medicaid when there are already such access problems," says Ms. Solomon. "We really tried to look for evidence of that. Anecdotally, people may say there are problems, but there really isn't a lot of research out there."

"Scalpel" approach taken

Ohio Medicaid reduced reimbursement for some CPT codes for community providers and also decreased the dispensing fee paid

to pharmacists. "You might say we took a scalpel approach, rather than a hatchet approach, to our provider rate reductions," says **Heather Burdette**, MBA, assistant deputy director of Ohio Health Plans. "This certainly served to mitigate any impact on access."

Additionally, with the decrease in private insurance enrollment and the increase in Medicaid enrollment, providers have some incentive to enroll in the Medicaid program to maintain their patient panel. "Even with the difficult decisions we have already made, our provider panel continues to grow at a steady rate," says Ms. Burdette.

In addition to tracking access with the fee-for-service program, the department works closely with its home health care case management agency and managed care plans to monitor access. "We are not seeing anything suggesting access to care has become a problem as a result of the changes we have implemented this last year," says Ms. Burdette.

During the last legislative session, a 25% rate reduction for Utah Medicaid's pediatric dentists was proposed. However, as Utah's dental reimbursement rate is acknowledged to be one of the lowest in the nation already, further reductions caused a concern about access.

The Centers for Medicare & Medicaid didn't approve the proposed reduction, however. Instead, a 4.5% reduction was allowed. "That will appease a lot of the dental providers in our state," says **Michael Hales**, the state's Medicaid director. "There was a big concern that many of those providers were going to exit the program. If we can keep rates to a more modest reduction, I think we will be able to maintain the majority of existing providers."

Michigan's Medicaid providers received a 4% rate reduction in FY 2009 and an additional 4% reduction for FY 2010, for a total of an 8% rate reduction since July 1, 2009.

Additionally, coverage of several optional services, including dental, vision, hearing, podiatry, and chiropractic was eliminated for adult beneficiaries.

Approximately two-thirds of Michigan's Medicaid beneficiaries are enrolled in Medicaid HMOs. "While this somewhat mitigates the impact of provider rate cuts on access to care, provider rate reductions, in general, are a cause for concern relative to access to care," says **Stephen Fitton**, director of the state's Medicaid program.

Contact Ms. Burdette at (614) 466-4443 or hburdett@ohio.gov, Mr. Fitton at (517) 241-7822 or fittons@michigan.gov, Mr. Hales at (801) 538-6689 or mthales@utah.gov, and Ms. Solomon at (202) 408-1080 or solomon@cbpp.org. ■

HIEs are major hurdle for Medicaid and HIT

A "master planning" approach is needed to effectively leverage all of the incentives and resources for building statewide Health Information Exchange (HIE) capacity, says **Lynn Dierker**, RN, project director for the Chicago-based AHIMA Foundation's state-level HIE Consensus Project.

"One of the most significant challenges is developing a real and effective working public-private collaboration involving state government," says Ms. Dierker. "There are cultural and operational challenges on both sides of this." This is true both for the state Medicaid agency as well as whatever multi-stakeholder organizational entity is leading governance and statewide HIE planning, says Ms. Dierker.

Working relationships need to be structured, expectations established, and day-to-day project management approaches agreed upon. "There is a new role in the mix, that of the state HIT coordinator, whose job is to foster collaboration across state agencies," says Ms. Dierker. "Historically, this has been a daunting challenge in many states."

To get in a better position to move forward with HIEs, Ms. Dierker says that state Medicaid agencies should be doing these things:

— Identify key personnel internally to be part of the collaborative efforts. These individuals should have, or be able to develop, a working knowledge to contribute to the agency's internal planning. "Strategically, it is important that agencies pursue internal working knowledge about statewide HIE development," says Ms. Dierker. "Given economic constraints, this may take some resourcefulness and creativity."

— Provide strategic leadership. This can be done by helping to identify use cases for HIE development that are part of deploying "meaningful use" payments, says Ms. Dierker.

— Work closely with the statewide HIE entity. This includes developing priorities for implementing HIE services to support "meaningful use" statewide.

"Many Medicaid agencies feel uncertain about federal-level expectations and are concerned about complying with federal guidelines," says Ms. Dierker. "Leadership is important now. Monitor developments, ask questions, clarify information, and compare notes."

This involves active communication and outreach, both to state HIE leaders across the country, to the Office of the National Coordinator, and to the federal Medicaid agency. The State HIE Leadership Forum

is a valuable resource for state HIE leaders, adds Ms. Dierker, including Medicaid agencies.

HIEs in early stages

"Health information exchanges are still emerging," says **Harry B. Rhodes**, MBA, RHIA, CHPS, CPHIMS, FAHIMA, director of practice leadership for the Chicago-based American Health Information Management Association. "Of the 150 HIE organizations identified in the 2009 e-Health Initiative survey, only 57 claim to be operational."

In addition, information exchanged may be limited to only certain types, such as laboratory, radiology reports, medication list, or claims. "This information is often only available in view-only mode," adds Mr. Rhodes. "Lack of discrete data elements and interoperability prevents information from being transferred directly from one EHR to another."

To get into a better position to move forward with HIEs, Rhodes says that state Medicaid directors should determine these factors:

— the critical elements of a workable HIE business plan;

— the key components of a business sustainability model, including how the HIE will be funded;

— the clinical value of participating in a HIE. "The ability to successfully collaborate with HIE stakeholders is an important critical success factor. It is just as important as HIE finance," says Mr. Rhodes.

Change is biggest challenge

Beth A. Nagel, health information technology manager for the Michigan Department of Community Health, says the biggest challenge with HIEs "is the fact that it fundamentally changes the way that many clinicians do their daily business."

"The technology is not the challenge," says Ms. Nagel. "The technology for HIE exists today and has been tried in many other industries. The biggest challenge will be getting clinicians to change their workflow to accommodate new processes while treating their patients."

Ms. Nagel adds that nationally, a big obstacle is funding sustainability. There is national debate on who should pay to plan, implement, and sustain the technology and organizational structures that are needed to support HIE.

"Many believe that the stakeholders who benefit from HIE should pay for it," says Ms. Nagel. "But it is very difficult to determine who it is that benefits. There are many benefits that reach many different stakeholders, including citizens."

Ultimately, providing the right information to health care providers at the moment of treatment is expected to reduce costs and improve quality. If a provider can see all of the diagnostic tests that have been previously run on a patient, then he or she may not choose to order the same tests.

"This will reduce the amount of redundant testing, which saves costs," says Ms. Nagel. "It will also allow the clinician to plan a course of testing and treatment for a patient in fewer visits, improving quality and health outcomes."

Contact Ms. Dierker at 312-233-1599 or lynn.dierker@ahima-foundation.org, Ms. Nagel at (517) 241-2064 or nagelb@michigan.gov, and Mr. Rhodes at (312) 233-1119 or harry.rhodes@ahima.org. ■

Crime lessens with better care

[*Editor's Note: This story is the second of a two-part series on improving care of high-risk youth enrolled in Medicaid. This month, we examine the impact of improved quality on subsequent contacts with the juvenile justice system. Last month, we reported on new approaches being utilized to improve care of this population.*]

Youth experiencing serious emotional disturbance make up about 15% to 20% of the population in juvenile justice facilities, according to **Laurel Stine**, director of federal relations at the Bazelon Center for Mental Health Law in Washington, DC.

"This rate is up to 10 times higher than their representation in the community," says Ms. Stine. "Between 60% and 80% of youth involved with the juvenile justice system meet the criteria for at least one psychiatric diagnosis. Of this

group, approximately 80% meet the criteria for two or more mental health or substance abuse disorders."

CEO **Knute Rotto**, director of the Dawn Project, an Indianapolis-based organization that works with youth and families served by multiple public systems, including Medicaid, points to data from 2008, the most recent year available. This indicates that 83% of youth were successful in staying out of the system, including juvenile justice, after leaving the program.

In addition, 94% of youth referred to the Dawn Project by the Marion Superior Court Juvenile Division did not engage in delinquent behaviors at the time of their most recent assessment, compared to only 50% at intake. "The Dawn Project has increased collaboration and coordination among child-serving systems. This has led to improved outcomes for youth and their families," says Mr. Rotto.

Strategy is cost-effective

Stephen A. Gilbertson, clinical program coordinator for Wraparound Milwaukee in Wisconsin, says there is no question that improving care of youth with serious emotional disturbance not only results in better medical outcomes, but it also reduces crime. "It is incredibly cost-effective," he says.

He points to a study dating back to 2001, which found that only 21% of 490 kids referred to the Wraparound Milwaukee program had no prior arrests or referrals to the juvenile justice system. Many of the youth had been found delinquent of serious and violent crimes prior to their Wraparound Milwaukee enrollment.

Over a five-year period, 60% of youth had no additional arrests or referrals while in the Wraparound Milwaukee program. During a one year post-enrollment period, 68% had no new arrests or juvenile justice referrals. Mr. Gilbertson says that these numbers have held steady over the years.

"We regularly track juvenile justice outcomes through our collaborative relationship with probation and the courts. Our findings have been consistent, if not somewhat improved, over the years," says Mr. Gilbertson. "Thankfully, we are finding that of those youth who have subsequent arrests, these tend to be non-violent misdemeanors vs. violent offenses resulting in incarceration."

Utilization of less restrictive care has resulted in better outcomes at a lower cost than the prior system, "which was heavily reliant upon long stays in residential treatment, repeated psychiatric hospitalization, and even incarceration," says Mr. Gilbertson.

Stringent authorization process

One thing that makes Wraparound Milwaukee unique is its status as a Medicaid behavioral health HMO. "Kids that are at risk for residential treatment or very high levels of care are enrolled in our managed care approach. We're at risk for the cost of their care, just like any traditional HMO," says Mr. Gilbertson. "Managing the care of this generally very high-cost, complex-needs population has proven to be very cost-effective."

Mr. Gilbertson credits Wraparound Milwaukee's success to several different approaches, including a prior authorization process done at the management level. In order for a child to enter into residential treatment, they need to be prior-authorized by a clinician within the administrative team.

"Any subsequent authorization has to go through a pretty extensive review process," Mr. Gilbertson says. "We are not turning over the decision of whether kids are ready to leave to the provider of the residential care. It's not completely in their hands to decide they need another three months of treatment."

Decision is collaborative

Instead, the decision is a collaborative process focused on outcomes. In order for that to work, though, there must be viable community-based alternatives to residential care.

"We've spent many years developing and enhancing the community-based services that are necessary," says Mr. Gilbertson. "In order to work effectively with these kids and their families, we have a real broad cadre of clinical and adjunctive services available in the community."

That includes crisis workers who intervene when a family is in crisis. A mobile urgent treatment team is available 24 hours a day, 7 days a week, staffed by clinicians who respond if there is an emergency or crisis that a family needs help with.

"Rather than the police necessarily having to be called, this clinical team can respond. This oftentimes diverts kids from having to be hospitalized, which is a huge savings," says Mr. Gilbertson. While the mobile urgent treatment team once served only youth enrolled in Medicaid, it now serves the entire community. It also has a contract with the public school system to respond to crises within the schools.

"So it's hitting all those situations where things can go wrong and can result in decisions being made that are costly, and also are not really in the best interest of the kid as far as outcomes are concerned," says Mr. Gilbertson.

This past year, a program called REACH was started within Wraparound Milwaukee, which allows parents to self-refer when

they are having difficulties with their kids. The program is in partnership with the Safe Schools Initiative, a federally funded program.

Whereas the traditional Wraparound Milwaukee program was reserved for youth already in the child welfare or juvenile justice system, the REACH program identifies them before that point. "It is available to any child who meets the 'serious emotional disturbance' and other Medicaid criteria," says Mr. Gilbertson. "By virtue of that, we are identifying vulnerable young people earlier."

The goal is to prevent more complicated youth and family problems that can result in out-of-home placements. "We are allowing them access to essentially the same mix of clinical and support services as are available within the traditional Wraparound Milwaukee program, although we obviously can't place REACH kids in foster or group homes or residential treatment without formal court involvement," says Mr. Gilbertson.

In both traditional Wraparound Milwaukee and REACH, a lot of work is done on the front end by care coordinators who visit the kids and families in their homes. The emphasis is on making things convenient. Assistance is provided for what families identify as their current concerns, as opposed to "expert-driven" care.

"There is a real emphasis on empowering families to have access to what they need in the community," says Mr. Gilbertson. "If they have a child who is chronically vulnerable, they need to know where to go to get help when they need it."

Contact Mr. Gilbertson at (414) 257-7209 or Stephen.Gilbertson@milwcnty.com and Ms. Stine at (202) 320-5100 or laurels@bazelon.org. ■