State Health Watch
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In This Issue

Health reform means major overhaul of Medicaid's eligibility systems

Providing seamless enrollment procedures is still a work in progress for state Medicaid programs under the current eligibility system, but doing so under health care reform is a health information technology (HIT) challenge of epic proportions.

Medicaid programs, some facing severe fiscal challenges, will have to upgrade or replace their outdated eligibility systems. Since this will require significant expenditures, one concern is the lack of enhanced federal financial participation (FFP). While direct costs of automated processing of claims, payments, and reports used in Medicaid Management Information Systems (MMIS) systems are eligible for enhanced reimbursement at 75% or 90% FFP, costs of eligibility systems receive only about a 50% FFP rate.

"That will be a key issue for states as they move forward," says **M. Reneé Bostick**, MPA, a Columbus, OH-based principal of Health Management Associates and former chief administrative officer of Ohio Health Plans. "That is a higher rate that states will have come up with in order to undertake changes in their eligibility systems."

Though the impact of system upgrades and changes necessitated

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Nevada Medicaid faces "cognitive fiscal dissonance"

With Medicaid enrollment increases of 3,000 a month showing no signs of slowing, having already made virtually all possible cuts to the program, and facing a projected $3 billion shortfall in the state, **Charles Duarte**, administrator for Nevada's Division of Health Care Financing and Policy, describes the process of planning for an estimated 150,000 more people coming onto the program as one of "cognitive fiscal dissonance."

The state has estimated that the federal requirement to expand Medicaid will cost Nevada $574 million from 2014 to 2019, when the 100% federal subsidy in the health care reform bill expires. Nevada has a $6.5 billion budget.

"So, when you are talking about a $3 billion shortfall, you are talking 40% of the state general revenue not being there in 2011," says Mr. Duarte. "We are using a lot of federal money for Medicaid that's not going to be around either, and on top of that, having to do health care reform. You put all those factors together, and it is one big question

Fiscal Fitness: How States Cope

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State Health Watch
The Newsletter on State Health Care Reform

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by health care reform encompass more than just Medicaid programs, Ms. Bostick says "the challenges will be exceedingly large in Medicaid. This is primarily because Medicaid eligibility systems have historically been tied to all social service programs."

Systems must share data

Today's systems have a modular structure, which allows data to be shared across programs. However, most eligibility programs used by states are decades-old legacy systems. This makes it difficult to change one aspect of the system without impacting the entire system.

In addition, Medicaid's systems will need to share data with the Health Insurance Exchanges (HIEs), a new mechanism for purchasing coverage included in the Patient Protection and Affordable Care Act. The HIEs are entities to be set up in states, and they will offer individuals a choice of health plans.

"What makes these types of projects so difficult is that they involve a very detailed understanding of eligibility policy," says Ms. Bostick. "In many states, this resides in the heads of a few people who understand the ins and outs of the eligibility program and know workarounds in eligibility systems."

These individuals also must have a keen understanding of the capabilities of modern technology, both in terms of web services and information sharing. In addition, all of Medicaid's various eligibility programs must be taken into account.

"One of the biggest things, I think, that holds promise for Medicaid is that you are not abandoning the social service structure," says Ms. Bostick. She says that first, Medicaid must determine the eligibility policies that need to be implemented through technology systems. Then, there must be a way to share that information across state programs, with appropriate controls for privacy and security. "The Department of Homeland Security, for example, shares information with the Department of Motor Vehicles. Similarly, these programs will need to share critical information but not be constrained by one another," says Ms. Bostick.

New mindset is needed

Aside from the purely technological aspects of revamping eligibility systems, another larger issue is on the horizon. This involves what Ms. Bostick refers to as "the rebranding of the Medicaid program externally."

"It is going to start with a big mindshift that Medicaid is a payer for health care and not a welfare program," says Ms. Bostick. "And that is not a shift that many states have made. They have focused more on other parts of the state system — and less on understanding the interoperability needs across the larger health care system."

Some organizations have even suggested changing the name of the program, in order to convey that it's more than just a government program. "Medicaid may be mandated by the federal government, and administered through the state governments, but it is a system of providers at the local level who are providing services to individuals," says Ms. Bostick.

Another complicating factor is the "gatekeeper" approach currently used for the Medicaid eligibility process. "Historically, much of Medicaid's role has been, on some level, determining who cannot come into the program," says Ms. Bostick. "With the larger policy shift, it will now need to start to look at how to expand coverage. Workers will no

longer be in their offices waiting for clients to come in. Instead, they will be conducting outreach activities to go out to where the clients are."

This is all part of "normalizing" health care coverage obtained through Medicaid, says Ms. Bostick. "It is really the final break to Medicaid being linked to welfare."

In order to revamp the eligibility process, "some Medicaid programs are thinking creatively," says Ms. Bostick. One example is identifying certain health care establishments to play a critical role in outreach, so that clients don't have to go to a social services office to be deemed eligible.

Databases can be used to validate a client's income, so a face-to-face contact isn't needed. Likewise, web capabilities can be used to determine eligibility for Medicaid, just as individuals can apply for unemployment benefits using a web application. "Information is validated by other sources, and communication and payment is all electronic," says Ms. Bostick. "Similar processes, I think, will be drivers in terms of Medicaid system reform."

Changing population

New individuals coming onto the program will change the population mix of Medicaid. This means that systems will need to implement new outreach approaches. In addition, these new eligibles will need to be tracked separately, as health care reform will provide enhanced reimbursement for certain populations for certain time frames.

"As complicated as eligibility is today, it will become even more complicated for a while into the future," says Ms. Bostick. "Most eligibility systems struggle to keep current with the complexity of eligibility today. With future populations reimbursed at differing rates at different points in time, that is going to be a huge challenge."

Currently, the largest population within the program consists of mothers and children; the aged, blind and disabled population is the next largest group. Medicaid's newly eligible population will consist largely of adults without children.

"This will be a big shift for the program," says Ms. Bostick. "This new population will largely be adults. One in six of those individuals coming onto the program are likely to have fair to poor health. At least a third will have chronic conditions that are likely to have worsened due to lack of preventive care."

Therefore, web capabilities are needed not only for eligibility, but also to get the new enrollees engaged in preventive care. Medicaid programs need to start thinking about how to "widen the on-ramps" for newly eligible individuals, says Ms. Bostick. For instance, text messages may be more effective for reaching certain populations.

"If you don't have real-time eligibility information, it makes it exceedingly difficult to do claims submission in real time, much less real-time clinical information exchange," says Ms. Bostick. "So, all of these are built on one another in a critically important way."

Some possible opportunities

Cindi Jones, acting director of Virginia's Department of Medical Assistance Services, says there are significant concerns regarding system capacity, as well as system changes that will be required based on the various provisions of federal health care reform.

"However, there are some opportunities for administrative simplification as well," says Ms. Jones. "We are eagerly anticipating guidance from CMS [the Centers for Medicare & Medicaid Services] regarding their interpretation of how states will deal with the expansion population relative to existing coverage groups."

This will help identify whether simplification can be achieved with the removal of categorical eligibility, and how the eligibility determination functions in Virginia will need to be altered under health care reform.

In many respects, the eligibility systems used in Virginia are somewhat dated and often difficult to modify. "But again, while this is a significant concern, we will not fully understand its implications until we better understand how CMS will interpret the reform changes," says Ms. Jones.

"For categories of eligibility which are essentially expanding based on higher income thresholds, the notion of administrative simplification is highly dependent on decisions at CMS regarding implementation," explains Ms. Jones.

She gives the example of parents and other caretaker adults who are categorically eligible today, albeit at a lower income level. It is not clear if any simplification can be achieved if the state must first apply the existing eligibility criteria to determine whether they would already have been eligible, before applying the new criteria associated with the expansion population.

However, due to the differing federal funding rates, some methodology must be developed to track this distinction.

"The same concern is there for childless adults, who may claim to be disabled, and whether or not a disability determination would need to be made," says Ms. Jones. "To the extent we must first rule out eligibility under current criteria before assessing eligibility under the new criteria, very little simplification will have been achieved."

Too many unknowns

Many decisions have not yet been made, any of which could

change how new eligibility systems get built. "There are a whole set of unanswered questions that, depending on how they are answered by the federal government and their guidance to us, may change how we have to structure the eligibility systems," says **Charles Duarte**, administrator for Nevada's Division of Health Care Financing and Policy. "Within that array of risk, and not having answers, what is the most feasible approach?"

Duarte, in reviewing the requirements for eligibility systems with the head of Nevada's Division of Welfare and Supportive Services, came to the conclusion that the current system can't be replaced and can't be amended.

The current system services not only the Medicaid population, but also the Temporary Assistance for Needy Families, child welfare, and food stamp populations. "It's an old system, not easily amended or enhanced," says Mr. Duarte. "The time frames are short, from a state and IT perspective, between now and 2014. Given that, and the fact that there is a whole matrix of risk with unanswered questions out there, what we are looking at right now is how can we basically bolt on an interim eligibility engine that will interface with an exchange and the current eligibility system?"

A feasibility study will be needed to determine if this approach is indeed possible, and if so, what the cost would be. "We know we can't replace the system, and we know that the system is not capable of being readily reprogrammed to meet the requirements for the new Medicaid world. So what do you do? You have to basically design something that can attach to the current system," says Mr. Duarte.

The "unknowns," though, are creating a risk environment for states, which need to begin planning before they have answers, says Mr. Duarte. "There are a host of questions out there. Until they are answered, we will be operating the best way we can. We are making a whole set of assumptions that may or may not be correct," he says. "There is a lot of guessing going on here."

On the state level, it's not yet determined whether Nevada will run its own HIEs, partner in a regional exchange, or just use a national exchange. "Another question is, 'Will all eligibility be done on the exchange? Or will the exchanges just be the front end for eligibility?'" asks Mr. Duarte.

On the national level, Mr. Duarte says that he wants to know how the federal government ultimately is going to require states to determine eligibility, both for the newly eligibles and the current eligibles. "And how are the tax credits and subsidies going to be paid? These questions could ultimately drive the design of these systems," says Mr. Duarte. "To do a good job, we really should have started planning two years ago. But, we have to do the best we can right now, in an environment where there are a lot of unknowns."

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Fiscal Fitness

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mark as to how we will do all of this or maintain the current program."

Currently, Nevada Medicaid is projecting an $82 million state general fund shortfall between now and the end of the state fiscal biennium in June 2011. In addition to the largest projected shortfall in revenue that Nevada has ever seen, there has been rapid growth in programs like Medicaid throughout the recession.

"Because of our dependence on tourism in general and our tax structure, we will probably see a recovery later than some other states," says Mr. Duarte. "What I have seen in national reports is that we are the fastest-growing program in terms of caseload. That has been fairly consistent."

The Medicaid program currently has a caseload of 256,000 individuals, up from around 180,000 two years ago. "Right now, we are at the highest level we have ever been at. We are continuing to grow at about 3,000 people a month, which for us is a very large number. As a result of caseload growth, we are continuing to project serious shortfalls in general funding for the program," says Mr. Duarte.

The program has gone through four cycles of budget reductions since 2008. "We've done practically everything that we could under the constraints of federal law," says Mr. Duarte. "We have touched on probably every aspect of the program, with the exception of eligibility. We have cut benefits, rates, and scope of services."

Cuts were made to hospital rates, physician rates, home, and community-based service rates. Coverage of certain optional items was eliminated, and restrictions were put on certain benefits, including personal care services.

Nevada reduced hospital inpatient rates by 5%, children's mental health rehabilitation service rates, and recently reduced reimbursements for anesthesiologists to levels consistent with other state Medicaid programs and the Medicare program.

"We are closely tracking access to care issues and may need to reconsider some of these cuts," said Mr. Duarte. During last February's special legislative session, Nevada Medicaid went through its fourth

round of budget cuts, trimming more than an additional $16 million in state general funds.

Planning is under way

In recognition of the urgency and depth of the planning process, two additional staff positions and some consulting services were approved by the state legislature. "The whole process is creating a tremendous workload issue for current staff," explains Mr. Duarte. "We are going to continue to be very dependent on existing personnel. We are dealing with furloughs and don't have any overtime available."

The additional staff will assist with multiple planning groups already established by the state. One large planning group was broken up into nine subcommittees, all looking at different aspects of health care reform. Some areas of focus are mental health, Medicaid, food stamps, the Temporary Assistance for Needy Families program, interface with the Medicaid program, and eligibility changes including system issues. Projections done through 2019 predict that Nevada Medicaid's caseload will actually decrease in 2015, due to expected improvements in the economy by that time. "That being said, we're still looking at adding on a significant number of additional people to the program. We are taking it to levels we've never experienced before," says Mr. Duarte.

Nevada is one of 20 states that are suing to block implementation of the health care legislation. "The direction that we've been given by our governor, despite that fact, is that the law is the law, until it's not the law," says Mr. Duarte. "And you have to start planning now, because if it's not overturned, you can't start planning then."

High cost of "woodwork"

"Frankly, most of the cost is not going to be with the new eligibles. It's with the people coming on who may be currently eligible but have never applied," says Mr. Duarte. "We call that the 'woodwork.' Some states have been criticized for having woodwork in their cost projections, but that's a fact of life."

If an individual is eligible for Medicaid, but has never applied for whatever reason, he or she may do so when the individual insurance mandate in health care reform requires him or her to obtain coverage. "So, I think that people will be driven into our programs as a result of that," says Mr. Duarte. "However, we think these folks may actually be healthier than others. This is primarily because if they weren't, then they would already be in our programs."

Another source of woodwork is an expected influx of employees at small companies coming onto the program, because their employer decides to stop offering coverage. Instead, these employees will be going through the Health Insurance Exchanges (HIEs) set up by the state to obtain coverage.

"We think we'll see a lot of folks come on that way, because there aren't any penalties for small employers to drop coverage," says Mr. Duarte. "And if you look at the average monthly wage of an employee of a company with less than 50 employees, they probably will qualify in a number of cases."

The woodwork of individuals already eligible for the program don't qualify for the enhanced federal match. However, there is an expectation that the newly eligible population will prove to be less costly than the current Medicaid population. "That is our current hope, anyway," says Mr. Duarte.

Projections are that the total of both the "woodwork" and the newly eligible will add 150,000 individuals to the program. This would take the number of enrolled individuals from 258,000 to 412,000 by 2019. "We don't put a lot of stock in those projections, but right now it's the best guess we can make," says Mr. Duarte.

Unfortunately, the new drug rebates included in health reform are not expected to help, and could actually hinder Nevada Medicaid's fiscal situation. "Right now, we are thinking we are going to lose money on this," says Mr. Duarte.

There are still some unanswered questions on the federal level. However, early estimates completed by the state point to a net loss of about $1 million as a result of the new rebate program.

"I have heard from a number of other states that they are also looking at this as a money loser, even with the managed care rebates," says Mr. Duarte. "However, how much they get in managed care rebates will be highly dependent on how their care delivery system is organized."

Nevada's managed care doesn't have anywhere near the pharmaceutical expenditure level of fee-for-service, explains Mr. Duarte. This is because typically, mothers and children are enrolled in managed care, as opposed to higher-cost clients. "So, the rebate levels will be pretty nominal for managed care," says Mr. Duarte. "Most of our rebates come in through our fee-for-service program, where our high-cost folks reside."

The best approach for tracking new vs. current eligibles also depends on some unanswered questions. "It could be easier, or more challenging, depending on the federal guidance we get. Theoretically, the law could be read in a way that allows CMS [the Centers for Medicare & Medicaid Services] to make it easier to do eligibility or any other aspect of the requirements," says Mr. Duarte. "There is a lot of opportunity there for CMS to help us. To be frank, I have not seen that play out yet, when we are dealing with issues already upon us, such as drug rebates. It seems that the direction we're get-

ting is we're going to be responsible for more administrative burden."

If a Medicaid program is going to lose money from the new drug rebate program, for example, and also has to spend money to administer it, "then it becomes basically a sharp stick in the eye," says Mr. Duarte. "It is not a benefit to the state."

Currently, Nevada Medicaid has a care coordination program in place for a targeted population of high-cost clients, primarily fee-for-service. A work group is looking at expanding similar quality initiatives included in the health care reform bill. Two of particular interest are non-payment of hospital-acquired infections and establishing different payment methodology to incentivize hospitals and physicians to do a better job of post-discharge care.

"We are very, very interested in some of the options for establishing a medical home," adds Mr. Duarte. "We have been working on that for about a year now, looking at program design. Now, this will give us additional federal matching funds to implement that." ■

California's Medi-Cal modernizing enrollment

California's Medi-Cal Eligibility System (MEDS) will need to be completely replaced to accommodate the changes necessary to implement health care reform, according to **Vivian Auble**, a senior consultant at Health Management Associates in Sacramento and former chief of California's Medi-Cal eligibility division. This could cost up to $250 million, not including costs to establish and operate the state insurance exchange, or to develop a new application and enrollment portal.

"It will not be possible to build upon the aging infrastructure that exists today, which is an aging legacy system more than 30 years old," says Auble.

The state will need to develop an online enrollment and application process, simplify eligibility rules and documentation requirements, and integrate systems to allow sharing of information among the state, counties, and the insurance exchanges.

"California will need to modernize its enrollment process to make it less cumbersome for applicants," says Ms. Auble. "Outdated technology makes it difficult to make policy changes quickly, accurately, or share information among programs. Manual processes that currently exist are time-consuming and prone to error."

Currently, MEDS is the only statewide system that stores all information on the almost 7 million Medi-Cal beneficiaries. MEDS also is used by the Medicaid Management Information System (MMIS) to track eligibles, claims payment and services, and draw down federal dollars. However, California's 58 counties operate four different county automated systems. These determine eligibility based primarily on mailed-in applications.

"The county systems have no ability to quickly make policy changes, and do not share information among themselves," says Ms. Auble. "The state will need to decide what role the counties will continue to play in eligibility determination."

California's Children's Health Insurance Program (CHIP) operates a separate online or mail-in system for its Healthy Families program. "Any new statewide system will need to have the capability of allowing online application, enrollment, and screening for Medi-Cal/CHIP or health insurance subsidies," says Ms. Auble.

The system must be able to transfer cases that are not eligible for Medi-Cal to the insurance exchange, for enrollment in one of the health plans offered.

"The state will also need to develop a uniform application that can be used to screen for Medi-Cal, subsidized care, or insurance exchange coverage," says Ms. Auble. "System development costs will be enormous."

In addition, California's MMIS system will require modification to enable accurate federal claiming of new eligibles. "However, costs will be minimal compared to the funding necessary to establish the exchange or develop the new online enrollment system," says Ms. Auble. "Developing a streamlined approach will be challenging in an environment with so many interested stakeholders, complex labor issues, and competing vendors."

The legislature's approval is required to develop the feasibility study report and to procure a vendor to develop the statewide online application and enrollment system.

"The state Health and Human Services Agency has recently been involved in a project to develop an online screening/application portal that could be used for many public assistance programs," notes Ms. Auble. "Much of the work related to that effort may be salvaged or adapted for the new online application process."

California already uses more than 150 codes to track eligibility for Medi-Cal, since the program covers so many optional and state-only groups. The changes that will be implemented for health care reform will provide an opportunity possibly to consolidate some of those existing aid categories and/or replace them with new ones. "This will enable accurate tracking of the new eligibles for federal claiming," says Ms. Auble.

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Medicaid patients far more likely to be readmitted

One of every 10 adult Medicaid patients hospitalized in 2007 for a medical condition other than childbirth had to be readmitted at least once within 30 days, according to an April 2010 report from the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ), All-Cause Hospital Readmission Rates among Non-Elderly Medicaid Patients, 2007. The report uses statistics generated from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases for 10 states.

Medicaid patients were 70% more likely to be readmitted than the privately insured, mainly due to underlying health problems. "Some of the findings were not particularly surprising. They echo what we knew already from the literature," says study author **H. Joanna Jiang**, PhD, a senior social scientist at AHRQ's Center for Delivery, Organization and Markets.

For example, an AHRQ study done several years ago compared readmissions for diabetes-related conditions among payer groups. The 30-day readmission rate was 11% for Medicaid compared to 8% for the privately insured, similar to the April 2010 report's findings. Another previous AHRQ study found that the risk for readmission increases substantially with the number of co-existing conditions, particularly if they are chronic. That finding also was confirmed in the new report.

However, Dr. Jiang says that "a few other findings were quite revealing, and not found in previous studies." For instance, Medicaid patients who were hospitalized for conditions that fall under five particular categories of disease accounted for more than half of the 30-day readmissions.

"This tells us which conditions or patient groups we would want to target, if we want to reduce readmissions," says Dr. Jiang. "Given a 10% readmission rate for the non-OB population, there is significant room for improvement, particularly in view of the gap in comparison to the privately insured."

Readmission is mentioned "almost everywhere" in the health care reform bill," says Dr. Jiang.

"This is definitely an area of focus in the coming years," she adds. "Facing the prospect of expansion in the Medicaid program with shrinking state budgets, tackling hospital readmissions may be an effective way to improve quality while reducing cost."

Challenging population

David Brody, MD, medical director of the Department of Managed Care at Denver (CO) Health Medical Center, says he wasn't surprised by the AHRQ statistics on Medicaid readmissions. "I think there are a number of factors that contribute to that," he says. "In the Medicaid population, you see more homelessness, you see more serious mental illness, and you see more substance abuse."

Dr. Brody adds that in his experience, a small number of patients who are very frequent readmitters contribute substantially to the readmission rate. "You provide whatever services are available, but at the end of the day, it's very difficult to have an impact on that population," he says.

Health care reform may have a positive impact on this. "To the extent that Medicaid eligibility is determined more by economic factors than chronic disease, I think we may see a trend toward the readmission rates looking more like the general population," says Dr. Brody. "But even under the best of circumstances, there is a core group of patients that are very difficult to keep out of the hospital." This is because in addition to whatever problem brought an adult Medicaid patient into the hospital, that patient is likely to have multiple comorbidities.

In Colorado, mental health services are "carved out" to managed care behavioral health organizations. "The disconnect between the mental health problems and the physical health problems makes it more challenging to treat," says Dr. Brody. "We don't pay for the treatment of the mental health problems, yet those mental health problems are contributing to our readmissions on the physical health side."

Access can be a more difficult challenge for Medicaid patients to begin with, either due to the availability of appointments or difficulty in navigating the system. This could be a contributing factor with avoidable readmissions. As for how the expansion of Medicaid will impact the ability to access care, Dr. Brody calls this "a big unknown."

"If the number of patients increase without a corresponding increase in providers, it could be even more challenging," says Dr. Brody. "On the other hand, if more patients are enrolled and more providers are available to see them, it could be easier."

Denver Health's nurse care managers routinely contact patients within 48 to 72 hours after discharge to find out if there are any obstacles in following treatment plans. "We identify lots of problems we can help patients with, although I'm not entirely convinced we have actually had much impact on the readmission rate," says Dr. Brody. "So our next step is to more aggressively do home assessments, both before discharge to be sure the home is a safe

place to discharge them to, as well as after discharge."

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Colorado Medicaid set to save millions on readmissions

Every year, Colorado Medicaid spends $20 million on hospital readmissions that occur within 30 days. This fact was brought to light as a result of a comprehensive data analysis done a year ago. It is one of the reasons that readmissions have become a key priority for the program.

"Not all of those readmissions are avoidable, but we think a pretty big percentage of them are," says **Sandeep Wadhwa**, MD, chief medical officer with the Colorado Department of Health Care Policy and Financing. "This is one of our top priority areas, in terms of initiatives that can reduce expenditures and also promote the health of our clients." The department's goal is to reduce readmissions by 5%, which would save $1.25 million annually. "That is the first step, and we think it is well within our reach," says **Jed Ziegenhagen**, manager of the rates section for the department.

Actionable information

"Right now, we are nearing the end of the analysis phase," says Dr. Wadhwa. The department's analysis looked at how readmission rates in Medicaid compared with Medicare, and also examined how different eligibility groups compared, such as pregnant women vs. elderly clients.

In the Medicaid program, 13.5% of hospitalizations are readmitted within 30 days, which is lower than the Medicare percentage. However, "apples to apples" comparisons are not always possible.

"It's hard to compare rates, as different entities use different metrics," says Mr. Ziegenhagen. Colorado is one of a number of state Medicaid agencies working with the Medicaid Medical Directors Learning Network to try to come up with a common metric for benchmarking readmission rates.

Though there is a lot of research on readmission rates in the literature, there is no standardized methodology to measure these rates. "We are working with other state Medicaid medical directors to come up with a consistent methodology by which we measure readmissions, so Medicaid programs aren't comparing apples to oranges," says Dr. Wadhwa.

While Medicaid's raw readmissions rates are lower than the Medicare rates, that may not be meaningful given the important differences in the two populations.

"We have a large number of pregnant moms, and our data shows that new moms tend to be readmitted less often than other patients discharged from hospitals," says Mr. Ziegenhagen. "If you adjust our data for the acuity of our populations, we think that we could do much better, especially compared to commercially insured people."

In addition, it is the underlying reasons for readmissions that make the information actionable. "It's important for Medicaid agencies to look at the reasons for readmissions, because they are going to be very different from what Medicare sees," says Dr. Wadhwa. "Heart failure is to Medicare what asthma is to Medicaid. We've got our own set of clinical opportunities."

Quality incentives

A year ago, a bill was passed to raise payments to hospitals through a provider fee with a quality incentive component. "We have been working with our hospital association to make readmissions one of four categories to make them eligible for the incentives," says Dr. Wadhwa. While increased revenue is one factor driving this, better clinical outcomes are another. "You've got to [be] a careful and prudent steward of the taxpayer's money. I think that's something all states care about in the current fiscal environment," says Mr. Ziegenhagen. "So, if there are needless readmissions we can avoid, that's compelling."

From the hospitals' point of view, readmission constitutes a bad clinical outcome. "This is not good for patients. There is a lot of research out there that shows a readmission is ultimately linked to increased rate of death and disease," says Mr. Ziegenhagen.

While the Medicare methodology looked more at the type of readmissions, Medicaid's data analysis focused more on the events behind those readmissions. "We felt that better reflected the costs of the Medicaid system," says Dr. Wadhwa. "It gave us a better sense of what we thought was impactable."

The analysis showed that almost 27% of admissions within 30 days happen within the first 24 hours. "This was a profound finding, that fully one quarter were same-day readmissions," says Dr. Wadhwa.

That finding spurred a key change in payment policy. Colorado Medicaid no longer pays for a same-day readmission that is clinically related, such as a patient admitted for surgery who has an infection related to that surgery, which brings the patient back into the hospital.

Even though new mothers have a low readmission rate overall, Medicaid pays for more than one-third of all deliveries in Colorado. Because of Medicaid's high share of payment for deliveries, despite that low rate of readmission, postnatal readmissions are the most frequent reason for readmission for Colorado Medicaid. "We'd really like to further dive into the data and see why new moms are coming back to the hospital and figure out a way to impact that," says Mr. Ziegenhagen.

"What is exciting is that we are seeing states take some of the findings on readmissions in the academic literature and say, 'How do we translate this research into policies for program improvement initiatives?'" says Dr. Wadhwa. "We are going through the heavy lifting of saying, 'Do our payment policies support readmissions? Can our payment policies incent reductions in readmissions?'"

Looking forward

Dr. Wadhwa says he believes that being proactive with prevention of avoidable readmissions will benefit Colorado Medicaid both in the long and the short term. "We are getting a head start out of fiscal necessity," he explains. "One of the sad features of this past recession was that when we would get budget forecasts that were worse than the previous forecasts, oftentimes we had to turn to rate reductions as our means of managing the budget."

Instead of continuing with this approach, attention is directed toward reducing inappropriate volume in the Medicaid program. "If we can ease the pressure on volume, that would mean we wouldn't always need to go to rate reduction," says Dr. Wadhwa. "We felt that there was a quality imperative as well. That brought readmissions high on our list."

Over a quarter of readmissions occurred at a different facility than the one from which the patient was discharged. "That percentage really spoke to us," says Dr. Wadhwa. "We wanted to look not just at same-facility readmissions, but also other facilities, but hospitals don't necessarily know about those events. So, that added to the complexity of solving the problem."

The statistic underscores the importance of looking at the bigger picture. "When we are speaking about readmissions that occur at other hospitals, there needs to be a discussion about the responsibility of the broader health community," says Mr. Ziegenhagen. "It's a mistake to say the hospital is totally to blame for any given readmission. It takes a community to avoid a readmission. Multiple folks are accountable for some part of the solution."

After a patient is discharged, the goal is for that patient to obtain a prompt referral to a primary care provider, preferably one who operates as a fully functional medical home. For this reason, there is a recognized need to give support to providers in the community. This includes nursing agencies, which see patients post-discharge.

Hospitals will begin receiving incentive payments based on their performance in FY 2011, with FY 2010 serving as the benchmark year. "We will measure results the following year, so we won't know if we succeeded in our 5% goal until then," says Mr. Ziegenhagen. "But we think that some of the activity around preventing readmission is generating savings right now."

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Different populations require different approaches

The Medicaid and Medicare populations call for two very different strategies for preventing hospital readmissions, according to **Michael Birnbaum**, director of policy at United Hospital Fund's Medicaid Institute in New York City.

"It's important to remember how different Medicaid's high-cost patients are, especially those with the highest costs," says Mr. Birnbaum. "Certain service delivery approaches developed to reduce Medicare spending may work very well for Medicare populations, but when they are applied to high-cost Medicaid patients, they just may not fit."

For example, people who are employed and privately insured are likely to have less severe mental health conditions, such as generalized anxiety disorder or mild to moderate depression, than people covered by Medicaid, who can't work due to severe mental illness.

"Medicaid cares for lots of adults who don't participate in the workforce for a broad number of reasons," says Mr. Birnbaum.

Sean Cavanaugh, United Hospital Fund's director of health care finance, says that when studies showed that 18% of Medicare patients were readmitted, the general reaction was, "That's much too high, and we can do better. What do we need to do?" He says that the same reaction is likely from Medicaid directors who learn of high readmission rates, but that the answer to the question "What can we do?" is likely to be different.

"The answer is they need to do the things that Medicare's new pay-

ment policies are encouraging, plus a lot more," he says. This is particularly true for high-cost clients, who are likely to have multiple comorbidities and a range of poverty-related problems, including housing issues.

When United Hospital Fund provided grants to several hospitals to learn more about their high-cost Medicaid patients, they saw "dramatic problems that extend beyond the health care system," says Mr. Cavanaugh. "Improving discharge planning and better transitions of care, and better handoffs from hospital to home care are important, but they are not nearly enough for this population."

While some high-cost clients are difficult or impossible to engage, members of another subset of this group are genuinely interested in improving their health. "From listening to our grantees, it seems that some high-cost Medicaid patients are almost impossible to engage," says Mr. Cavanaugh. "However, others, even with all of their problems, respond to new programs and forms of assistance."

Still, getting Medicaid beneficiaries to respond to some of the more traditional approaches for Medicare populations, such as better discharge planning, can be challenging.

"When you talk about discharge planning, for Medicare beneficiaries the assumption is that you have family caregivers, a relatively stable home environment, and at least the home health benefits covered by Medicare," says Mr. Birnbaum. In contrast, with Medicaid's high-cost cohort, you may face a patient with unstable housing arrangements and weak family and social supports. In addition, the beneficiary may reside in a state without robust home care benefits.

"So, there are core assumptions about how you approach discharge planning in Medicare that just don't translate to Medicaid. And then there's the matter of implementing a plan of care for a schizophrenic with a chemical dependency, a challenge that's essentially faced only by Medicaid," says Mr. Birnbaum.

Mr. Cavanaugh gives the example of diabetics. "This is a group of people you don't want to see hospitalized ever, and certainly not rehospitalized. That is considered a preventable admission," he says. The usual approach is to give the patient glucose monitors to check blood sugar at home, with a home health nurse sent occasionally if there is a need to enhance the intervention.

"That all makes a lot of sense for many Medicare patients. But when you go to the Medicaid context, let's say the patient has an unstable home situation. The glucose meter might get lost or damaged, and you don't know how to follow them if you want to call them," says Mr. Cavanaugh.

Novel approaches

Some enhanced intervention programs are now giving cell phones to high-cost users, paid for outside of Medicaid, so they can be contacted for follow-up. "Under the old math, it didn't make sense for anybody to do this," says Cavanaugh. "Who is going to give a patient a cell phone and not get paid by Medicaid, to try to reduce utilization that is getting reimbursed by Medicaid?"

However, if payment policies don't pay for avoidable readmissions, "then the math starts changing. Some of these changes on the margins start to make more sense," says Mr. Cavanaugh. "I think we are a long way from solving this, but I think health care reform is starting the conversation about changing the reimbursement structures."

On the Medicare side, in contrast, there is a lot of robust information about what works. This means that the federal government can institute clear incentives and even penalties on the fee-for-service side.

"With Medicare, you can do readmission penalties and value-based purchasing and hospital-acquired condition penalties," says Mr. Birnbaum. "But this is still in the development stage on the Medicaid side."

Another factor is that in a fee-for-service environment, high-cost patients for Medicaid are high-revenue patients for hospitals. "So, when you're talking about changing the math, you really need providers at the table," he says. "Right now, providers can have strong incentives to admit and readmit Medicaid patients."

The potential impact of health care reform on rethinking service delivery for Medicaid patients is substantial. "You have $10 billion

in new federal pilot funding. These are not, by necessity, budget-neutral demonstrations. There is money on the table and a lot of focus on making new investments to see what works," Mr. Birnbaum says.

Once again, though, the outlooks are quite different for Medicare and Medicaid. "On the Medicare side, there is an opportunity to save substantial money because of policies that have already been developed and have just been enacted," says Mr. Birnbaum. "On the Medicaid side, you are hoping for some bright ideas, not even necessarily to take hold, but to bubble up, so they can be tested and refined. For Medicaid, this is definitely at an embryonic stage."

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Nursing facility care: duals shifted away from Medicaid?

Over half of nursing facility residents are dual-eligibles. This means they must contend with a system of care that often is not well-coordinated or efficient.

However, there are potential opportunities to improve care for dual-eligibles by shifting their care in long-term nursing facility services from Medicaid to Medicare, according to a March 2010 brief from Mathematica Policy Research, a Princeton, NJ-based nonpartisan research firm, *Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement*.

This would be a major change, acknowledges Mathematica senior fellow **James Verdier**, author of the brief. "I wouldn't expect it to happen right away or without a lot of discussion about the pros and cons," says Mr. Verdier.

There are currently significant problems with coordinating and monitoring prescription drug use in nursing facilities. While Medicare is responsible for the drug benefit for dual-eligibles, Medicaid doesn't get any data on the types of prescription drugs being used in nursing facilities by these residents, even when their nursing facility care is being paid for by Medicaid.

"Most of the Medicare Part D drug plans don't really have the resources or the incentives to closely monitor the prescription drugs used in nursing facilities for either clinical or cost-effectiveness," says Mr. Verdier. "There are a lot of problems on the prescription drug side that could be dealt with more effectively if Medicare was responsible not just for short-term post-acute nursing facility care, but also the long-term care for which Medicaid is now responsible."

The change might also prevent avoidable hospitalizations. "Right now, there are significant financial benefits for nursing facilities if a resident goes into a hospital for three days and then comes back," says Mr. Verdier. "They typically get a higher Medicare reimbursement for a period of time for that resident."

In theory, a lot of things could be done in nursing facilities that would reduce the risk of that kind of hospitalization. For example, prevention of pressure sores and various exacerbations of chronic diseases and illnesses could prevent someone from being admitted to a hospital. "The nursing facility itself, with support from Medicaid, could do that," says Mr. Verdier.

However, Medicaid lacks any financial incentive to fund these kinds of activities within nursing facilities, because the savings would all accrue to Medicare and not to Medicaid. "If there was a single payer, Medicare, that was responsible for both the nursing facility care and the hospital care, they would have every incentive to reduce hospital care and also the ability to pay extra amounts from hospital savings to provide the kind of care in the nursing facility that would prevent someone from having to go into the hospital," says Mr. Verdier.

Currently, Medicare is responsible for only about 20% of the market for nursing facility care. Medicaid pays for over 40% and private pay for most of the remainder, including a very small amount from private insurance.

"So, Medicare doesn't have as much leverage over what goes on in nursing facilities or for how their performance is monitored and rewarded, as they would if they had financial responsibility not only for the portion of that they now pay, but the portion that Medicaid now pays, as well," says Mr. Verdier.

Looking forward

Pilot programs are currently under way looking at avoiding unnecessary hospitalizations and re-hospitalizations, including within nursing facilities. While many people in nursing facilities are there because they have serious illnesses and disabilities — and it's not surprising to see some of them get admitted to the hospital — many admissions could be prevented.

"There really is an opportunity to reduce a lot of those hospitalizations, if only because the financial incentives to hospitalize people are now so great," says Mr. Verdier. "Just changing those financial incentives, all by itself, could have a significant impact."

A Federal Coordinated Health Care Office was established by the new health care reform legislation,

responsible for supporting state efforts to coordinate and align acute care and long-term care services for duals. "By setting up this new office, and having the head of this office report directly to the administrator of CMS [the Centers for Medicare & Medicaid Services], that really emphasizes the importance of dual-eligible issues as part of the health care reform legislation," says Mr. Verdier.

Mr. Verdier is also working on a project with the Medicare Payment Advisory Commission (MedPAC) that will examine programs aimed at improving the coordination of care for dual-eligibles, including long-term care and nursing facilities. "We will be doing some site visits with MedPAC staff to especially promising models," says Mr. Verdier. "So there is a growing interest in the whole dual-eligibles issue, and nursing facilities are a part of that."

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