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Who will comprise Medicaid's expansion population?

While state Medicaid programs have projected the expected number of individuals coming in to the program in 2014 as a result of health care reform, it's less understood who these individuals will be. Are they a relatively healthy group, or are do they have complex, costly health care needs?

"That's the million dollar question. There are many folks trying to put the pieces of the puzzle together," says **Allison Hamblin**, director of complex populations for the Hamilton, NJ-based Center for Health Care Strategies (CHCS). "Once states determine how to deal

with enrollment, the next step is quickly assessing the needs of new enrollees."

Don't make assumptions

The picture that is emerging of the estimated 17 million Americans who will become newly eligible for Medicaid in 2014 suggests that it's a mistake to make blanket statements about this group.

"People carry around a lot of assumptions about who these folks are. This is a heterogeneous population," says **Alan Weil**, JD, MPP,

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Connecticut is first to take advantage of early expansion

The option to expand Medicaid coverage to childless adults immediately, instead of waiting until 2014, is one fiscal opportunity for states included in health care reform legislation. In April 2010, Connecticut became the first state to formally seek approval under the new federal law to cover more individuals under Medicaid.

"We were the first state to take advantage of the opportunity to expand Medicaid coverage to a new population of low-income adults. That alone will net the state \$53 million through June 30, 2011,"

says **Michael P. Starkowski**, commissioner of Connecticut's Department of Social Services. "We think that is going to be a big plus, both for the state and for low-income adults previously covered under our state-funded general assistance program."

The state is transferring 47,000 single, low-income adults covered by State-Administered General Assistance (SAGA) into the larger Medicaid program. Currently,

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**Fiscal Fitness:
How States Cope**

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Cover story

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executive director at the National Academy for State Health Policy in Washington, DC.

“There certainly are some new eligibles who are sick and maybe have some mental health or substance abuse issues, and we need to be prepared for that,” says Mr. Weil. “There are some who are really quite disabled but don’t meet the [Supplemental Security Income] SSI disability standards. There also are a lot of people who are basically healthy and are just disconnected from the insurance system. It’s not, ‘We’re getting a bunch of these.’ It’s important not to generalize.”

Mr. Weil says that “the good news is there are some good reports on this topic that are disentangling this from a data perspective,” he says. “They are based on data — not assumptions.”

Two generalizations are either that there is a lot of pent-up demand for health care services in the population, or they are generally a healthy group. “In some segments, there will be pent-up demand. And a lot are healthy, but not all,” says Mr. Weil. “So, it’s not all one answer.”

Put information to use

“One good thing is that we actually do know something about this population, and that can help us prepare,” says Mr. Weil. He adds that this information is important for state Medicaid directors to have for several reasons.

One reason is the ability to do more effective outreach for enrollment. “Because these people are newly eligible, they are not going to magically know it. We will have to reach out to these communities and find these folks,” says Mr. Weil. “The more we know about

who they are and where they live, the more likely we will be able to reach and enroll them.”

With more knowledge about the health needs of the population, Medicaid programs can work more effectively with the managed care plans or traditional safety net providers who will be delivering care. “This is an opportunity to talk about what kind of care coordination you will need to meet the needs of the population,” says Mr. Weil.

The needs of high-cost clients in the newly eligible group are not homogeneous, either. These may involve substance abuse, physical disabilities, or multiple chronic conditions.

“There is not a ‘one size fits all’ approach to high-cost Medicaid folks,” says Mr. Weil. “The important thing is to engage with providers with whatever knowledge you do have about the health status of the population.”

Information about the population’s health status will become important during negotiation of rates with payers. “Given the heavy reliance on managed care, with a large influx of new people, the plans will want to build in a cushion, so that they don’t lose money on this group. Naturally, they will err on the high side with their estimates,” says Mr. Weil.

Even with available data, there is clearly some uncertainty about how expensive the new population will be. “In the early years, it may be that a risk-sharing arrangement is worked out to make sure that the state isn’t paying too much, but the plans don’t go under,” says Mr. Weil.

“Woodwork” is one concern

Brian Blase, a policy analyst at the Heritage Foundation’s Center for Health Policy Studies in Washington, DC, says that the actual numbers of new enrollees

will vary “pretty drastically by state. States which already have pretty generous eligibility, such as Maine, Massachusetts, New York, Hawaii and Vermont, won’t experience as robust enrollment. Others are going to be more impacted.”

The Heritage Foundation found that estimated enrollment increases by state varied, ranging from an expected 9% increase for Massachusetts to an expected 66% increase for Nevada. “As it turns out, the states that had the most opposition to the bill will be the ones most dramatically impacted,” says Mr. Blase.

Mr. Blase says that there is some evidence that indicates the expansion population is going to be “relatively unhealthy” compared to the existing Medicaid population. He points to an analysis done by the United Health Group, based on Medical Expenditure Panel Survey data, which estimated that the cost to cover adults without dependent children is 15% higher than for parents.

“It’s hard to know exactly how accurate these estimates are, but really unhealthy individuals — those who are disabled and can’t work — will probably already qualify for Medicaid or Medicare,” says Mr. Blase.

The “woodwork” effect is a concern for states. “An enormous amount of people are eligible for Medicaid, but they just haven’t enrolled. A major concern for states is — if people respond to advertising — that if someone doesn’t have insurance, they will pay a penalty,” says Mr. Blase.

If these individuals are deemed eligible under the old criteria, then the state’s federal match rate would be the lower standard match rate. “This is all happening when states are experiencing the worst fiscal crisis in a generation,” says Mr. Blase.

According to a report from the Kaiser Commission on Medicaid and the Uninsured in Washington, DC, 41 states already cut reimbursement rates in 2009 or 2010,

and 39 states cut either Medicaid pharmaceutical benefits or medical benefits.

“One of the main criticisms of Medicaid is that individuals don’t have access to physicians, so they utilize ERs. That problem, presumably, is becoming exacerbated because of the recent cuts to provider rates,” says Mr. Blase.

Health care reform requires that states increase primary care rates to Medicare levels for 2013 and 2014, with the federal government paying the cost. “But there’s a problem. In 2015, funding for that goes away. At that point, doctors are going to have had elevated rates for two years,” says Blase. “States are either going to continue that, or cut the rates and have to anger doctors and worry about access. Either one is going to be problematic for different reasons.”

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Fiscal Fitness

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the cost for this coverage is borne entirely by the state, and the benefit level is inferior to Medicaid.

“While the clients will receive more health care benefits to meet what are often complex needs, the federal financial participation is really going to help the state budget,” says Mr. Starkowski. “It is also an opportunity to move into new populations that have had difficulty getting affordable health insurance, because the new program is open to all adults with very low incomes, whether or not they have children.”

The state already offered coverage to childless adults without health insurance through its Charter Oak Health Plan, opened as an option

for adults with or without pre-existing conditions by Gov. M. Jodi Rell in 1998. The subsidization of premiums was discontinued due to budget constraints.

Previously, Charter Oak’s enrollees paid premiums depending on their income, and those who hit 300% FPL paid the full, unsubsidized premium. As of this July, the legislature eliminated the subsidization of the program, so clients now pay \$307 a month regardless of income. About 2,000 are now eligible for the new low-income adult program.

“That will be a plus for quite a few people in Connecticut, because if they move, they don’t have the co-pays or deductibles,” says Mr. Starkowski. “By moving, they don’t have any premium at all, and they will move into the

full Medicaid package.”

Coverage is retroactive

While many states aren’t able to take advantage of early expansion because of budget shortfalls, several factors made Connecticut a good candidate to capitalize on this.

First, Connecticut had already been providing a health care benefit with its SAGA program. This provided medical coverage to very low-income, single, childless adults who do not qualify for Medicaid because they are under age 65, do not have a permanent qualifying disability, are not pregnant, or do not have a child under age 19.

“These were very low-income individuals with an average monthly income of \$600, who did not have the ability to purchase insurance,”

says Mr. Starkowski. “Many had some type of temporary disabilities or substance abuse issues, which kept them out of employment for six or nine months.”

Before health care reform was passed, the legislature authorized the filing of a waiver with the Centers for Medicare & Medicaid Services (CMS) to try and gain federal reimbursement for this population. “The administration worked with the legislature and talked to CMS about waiting until health care reform passed,” says Mr. Starkowski.

He says that the process of working with the federal government went very smoothly. “It was a very pleasant experience. [Health and Human Services Secretary Kathleen Sebelius] assigned individuals in her department who had the expertise to actually make decisions on eligibility, assets, program design, network adequacy, and the transition,” says Mr. Starkowski.

After the state plan amendment was submitted to the federal government, a series of conference calls was held with the appropriate decision makers in each area. “They would tell us what outstanding issues still needed to be resolved,” says Mr. Starkowski. “My staff and myself, as the decision makers for the department, would make decisions on the phone.”

After moving through all of the issues that had to be resolved to get the expansion population covered, Connecticut was approved. The Medicaid coverage and federal revenue for the expansion population is retroactive to April 1, 2010.

“That enabled us to hit the ground running,” says Mr. Starkowski. “It actually means about \$53 million in net savings to the state of Connecticut between April 1, 2010, and June 30, 2011. And on a regular basis, it means enhanced revenue.”

Mr. Starkowski says that “in a way, the timing was right,” because Connecticut was able to be an ‘early

adopter’ of national health care reform legislation.

“The federal government recognized that we had been doing the right thing, so to speak, for years by covering this population,” says Mr. Starkowski. “Now, for the first time, we are getting partial federal reimbursement to complement that state expenditure, and the clients are getting a better health care benefits package through Medicaid.”

In addition to the 47,000 individuals who have already been transitioned into the program, and 2,000 moved from the Charter Oak program, an estimated 5,000 people will come in over the next year.

“It will cost us some dollars. We understand that we will still get our standard FMAP of 50 cents on the dollar,” says Mr. Starkowski. “But we believe it will provide some stability to the health care system and some certainty of payment for the providers who service this population. In the long run, it will provide enhanced health care and quality of life for the people who live in the state.”

Premiums reduced

Individuals with pre-existing medical conditions who have not had health insurance for the past six months can now get coverage under the Connecticut Pre-Existing Condition Insurance Plan, opened by Gov. Rell on Aug. 1, 2010.

Connecticut will receive \$50 million from the federal government over the next three and a half years to pay the expenses of the individuals who enroll in the high-risk pool.

“In June 2010, after we received the preliminary premium schedule for individuals in the high-risk pool, Governor Rell sent us all back to the drawing board to have our actuaries once again review the premiums,” says Mr. Starkowski. “We worked with CMS to try to bring

those down to much more affordable premiums.”

Premiums were lowered by 35% over initial estimates. They now start at \$285 monthly for those under 30, and rise gradually by age to a high of \$893 for adults 65 and older. An average of 1,200 people a month are expected to be served by the program.

When an individual applies for the plan, he or she is first screened for Medicaid eligibility. “If they have a pre-existing condition and [are] eligible for Medicaid, that would be the least costly and most expansive service for the individual, because there wouldn’t be any co-pays or premium shares or deductibles,” says Mr. Starkowski.

In some cases, an applicant may not be aware of the federal requirement for an individual to verify they have been without any insurance in the previous six months. Therefore, if someone’s COBRA coverage ended two months earlier, he or she would not be eligible for the Pre-Existing plan. In that case, even if the individual isn’t eligible for Medicaid, he or she can still be offered the Charter Oak Health Plan.

“We are trying to put a package together where clients can come in, send in an application, and our contractor will come in and find the most appropriate plan for them, based on their medical needs and their income,” says Mr. Starkowski.

Mr. Starkowski says that he does have some concerns about the fiscal impact of the expansion population. “I think it’s going to be a positive thing for the clients. On the other hand, I think it will potentially increase the number of enrollees that we have on the Medicaid program, just from the screening process,” he says.

Looking forward

“I think we have been a fairly pro-

gressive state with health care,” says Mr. Starkowski. “We haven’t been wed to staying in a mode of service from the past. We are always looking at what’s out there — what are the best practices that could make it a more cost-effective and more quality-driven process. We’ve had some significant expansions in our programs. Some other states have provided the minimum eligibility requirements, but Connecticut has never been that way.”

The department provides services for some 550,000 people in the state,

including Medicaid, single-purpose pharmacy programs, the Husky A, Husky B, and Charter Oak programs, and the fee-for-service Aged, Blind and Disabled population. “For a significant population, we are the backbone of their health care, or we are at least providing primary access for things like pharmaceutical benefits,” says Mr. Starkowski.

However, with a projected deficit of about \$3 billion in its 2012-2013 budget, the 2014 expansion population is going to be another strain on the fiscal problems the state is

already facing.

“As much as we have moved into some of the expansion territory already with the Medicaid for Low-Income Adults program, it still only reimburses states at 50 cents on the dollar, because that is our FMAP,” says Mr. Starkowski. “So, it is still a challenge for us, because we are going to have to come up with the dollar in order to get the 50 cents.”

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What are true MFP results? A clearer picture emerges

There is a lot of current interest in the “rebalancing” of state long-term care systems between nursing facilities and home and community-based care. However, to know how far you’ve come, you’ve got to know where you started out.

Now, a new report provides data on where states stood before implementation of the Money Follows the Person (MFP) demonstration, a federal initiative launched in 2005. The program was extended in 2010 as part of the Patient Protection and Affordable Care Act.

The May 2010 report from Mathematica Policy Research, *The Starting Point: The Balance of State Long-Term Care Systems Before the Implementation of the Money Follows the Person Demonstration*, says that in 2005, of the 2.79 million Medicaid beneficiaries who used long-term care services in MFP grantee states, 60% received home and community-based care services (HCBS). However, HCBS accounted for only 38% of spending for total long-term care services.

It’s important to establish a baseline of currently existing services, as the MFP program aims to transition long-term care users out of institutions and into HCBS settings, says **Carol V. Irvin**, PhD, a senior

researcher at Mathematica and co-author of the report. The report is the fourth in a series, and is part of a comprehensive evaluation of MFP.

Whereas previous work has been based on the aggregate reports that states send to the Centers for Medicare & Medicaid Services (CMS), Mathematica’s research was based on person-level data.

“When you use aggregate data, you as a researcher are constrained with what you can do with that information,” says Dr. Irvin. “With person-level data, we can slice and dice the data in ways you just can’t do with state aggregate data. That is where our contribution comes in — with our work.” The researchers were able to look at the balance of subgroups within HCBS, such as differences between individuals new to long-term care vs. those who had been in for at least two years.

State-plan vs. waiver

States that already have large percentages of long-term care users receiving HCBS when they launched the MFP program typically offer these as state-plan services, as opposed to waiver services. “When a state offers personal care assistance or home health services as

a state-plan service, it is essentially offered to everybody in Medicaid. So, it is much more readily available,” explains Dr. Irvin.

While most programs do have a referral process or some type of check to confirm the recipient actually needs personal care or home health services, it is much easier for individuals to access the services than if they are offered only through a waiver program. In that case, only those people eligible for the waiver services can access those services.

“In many states, waivers are small programs and may be limited to one geographic region. So, accessing those services can be more difficult,” says Dr. Irvin. “That’s one way a state can limit access to something like personal care or home health, although you do see states that have decided to make a very strong commitment to their waiver programs, with programs that are very generous and provide a very comprehensive array of services.”

Fiscal evaluation is tricky

“On both the state and federal level, the fiscal issue is something that we don’t have a good sense of right now,” says Dr. Irvin. “It’s a little too early. A lot of the focus has

been on getting the programs up and going.”

Dr. Irvin says that states need to be careful about measuring what she calls “the counterfactual.” In other words, you are looking at what would have happened if MFP had not existed.

“How you measure that is tricky, and there is a whole art to that,” says Dr. Irvin. “States that need to have a very quick answer for policymakers don’t always pay enough attention to that aspect of their calculation.”

Trying to figure out what the state of things would have been if a program had never been put into place, says Dr. Irvin, is something that evaluators struggle with all the time. “Many times, that is an important factor in your ability to measure the outcome,” she says.

Researchers looked at three years leading up to the implementation of MFP in 2008 to establish a baseline. Future research will compare 2005-2007 with multiple years in the MFP period.

“If we see any large differences that we can’t explain with other events, such as the advent of other programs, then we will assume that MFP had a role,” says Dr. Irvin. For instance, if the proportion of individuals using HCBS was increasing 4% a year before MFP was implemented, and then increased 10% a year afterward, and there is nothing else to explain that increase, then at least some of that increase would be attributed to MFP.

Going state by state

The size of HCBS programs varies widely across states. Expenditures on HCBS ranged from 13% to 59% of total long-term care spending. The proportion of HCBS users ranged from 24% to 83%.

Because of this large variability, researchers will need to determine the overall impact of MFP in each individual state. “If we can identify

particular states where we do see an impact, that’s going to be very important,” says Dr. Irvin.

If a particular state devoted a large proportion of its long-term care dollars to HCBS before MFP was ever implemented, things may not change a lot in that state. In other states, though, MFP might be critical to tipping the balance of long-term care spending toward HCBS.

“We are going to have to evaluate results state-by-state. But because we are a national evaluator, we will have to come up with an overall statement on MFP’s result on cost and health outcomes — with a lot of caveats,” says Dr. Irvin. For example, researchers will be noting whether a much larger impact was seen in particular types of states.

Further complicating the conclusions is the fact that states are also working on nursing home diversion programs, in addition to MFP programs. “These are becoming bigger and more prominent and established. And those are some of the very same trends we are looking at with MFP,” says Dr. Irvin. “We are looking at whether we will be able to satisfactorily control for that.”

It may be difficult to pinpoint what percentage of the changes to attribute to MFP, as opposed to a nursing home diversion program. “That is why our evaluation of MFP is going to be multifaceted,” says Dr. Irvin. “We are not looking at just the state-level impact. We are looking at the individual level as well. That’s probably where some of our strongest work is going to be.”

The goal is to determine the impact on an individual’s utilization of health care services, and the cost and quality of that care. In order to do this type of evaluation, states are collecting quality-of-life data on MFP participants, right before they transitioned to community living and after one or two years.

“Some of that work will be par-

ticularly important in answering ‘What is the impact of MFP?’” says Dr. Irvin.

Is it cost-effective?

The 21 states without MFP programs in place have another chance to apply, as a result of the program’s extension. “So, there is an opportunity for more states to benefit from this program. But we know that due to budget issues, many states have not gotten the extra waiver slots they wanted to expand their MFP programs. Some of the programs are being heavily affected,” says Dr. Irvin.

States without MFP programs still need to pay their share of the program costs, even though much of the cost will be covered with enhanced federal dollars.

“Some will say that they are not prepared to do that, but we hope not all of them,” says Dr. Irvin. “We hope that there will be a number who apply, but it is a very tough fiscal environment right now. There is no doubt about that.”

There is now a strong sense that HCBS is the right thing to do for people, but is this kind of effort also cost-effective? “At this point, the jury is still out in terms of whether community living makes sense from a fiscal point of view,” says Dr. Irvin. “You can think of all kinds of additional risks that someone might face if they don’t have constant care by their side.”

To assess this aspect of community living, researchers will examine how various quality-of-care measures differ from institutional and home settings. These will include mortality, preventable hospitalizations, emergency department visits, and the overall cost of care.

“Can we demonstrate that when an individual is living in the community, the overall health care costs are less than if that individual is in a facility? The research community is not

convinced that we have the data that demonstrate that,” says Dr. Irvin. “It takes money to have someone living in the community as well.”

When an individual is living in a facility, Medicaid is not only paying for their health care, but also room

and board. That is not the case when that person moves to the community.

“Is that a cost savings right there? Or is it just a matter of costs getting shifted to another program or to the family?” asks Dr. Irvin. “Are your health costs, in fact, less when

you are out in the community, or are they more because you are more likely to have a fall or an accident or infection? These are all things that we will look at.”

Contact Dr. Irvin at (617) 301-8972 or cirvin@mathematica-mpr.com. ■

Medicaid broadens long-term care option

Georgia, like many states, is in the process of collecting data to show the results of its Money Follows the Person (MFP) program. “To date, 305 individuals left the nursing home and returned to the community,” reports **Alice Hogan**, PMP, program director for Waiver Services at the Georgia Department of Community Health’s Division of Medicaid, and acting project director for the state’s MFP program.

Each of those individuals has completed a quality-of-life survey, designed by Cambridge, MA-based Mathematica Policy Research, prior to being discharged from the facility. This survey is completed again after the individual has been in the community for one year, and again at two years post-discharge.

Researchers at Georgia State University’s Health Policy Center in Atlanta will be collecting and analyzing these data as they come in, along with cost data, service utilization, and other factors indicating program success.

“This spring, we have just reached our first large group of individuals who have completed the one year of participation in MFP. So, we have not yet had sufficient data to analyze,” says Ms. Hogan. “We do expect to see that the cost to provide care for individuals is less in the community, and that they do have a better quality of life.”

The program already has some anecdotal evidence to support that. “We have already heard from many of the one-year participants that the program has been instrumental in

increasing their quality of life,” says Ms. Hogan.

Georgia’s program is expected to grow, in part due to the extension of MFP through 2016. “This will give us the time and funding to transition more individuals than originally planned,” says Ms. Hogan. “We have expanded staffing in the state office to support this effort going forward.” This includes a housing specialist position to make affordable, accessible housing available throughout the state.

Target correct individuals

A November 2009 Mathematica Policy Research report, *Early Implementation Experiences of State MFP Programs*, suggests there are a number of challenges facing states, including lack of affordable housing and worsening state budgets. This affects the state’s ability to manage the program and build up capacity for home and community-based care services.

Almost 6,000 individuals had been transitioned through the program as of December 2009, according to a June 2010 letter from the Centers for Medicare & Medicaid Services (CMS) to state Medicaid directors. States currently in MFP have a goal of transitioning a total of 34,000 individuals by 2013.

“Mathematica’s data showed that 2,790,000 people received long-term care services in institutions or in the community through Medicaid in the states participating in MFP,” says **Donna Folkemer**, a group director

at the National Conference of State Legislatures in Washington, DC, and former chief of policy and planning for the District of Columbia Medicaid Program.

“MFP is focused on a relatively narrow subset of Medicaid long-term care users. The key is to target the correct individuals,” says Ms. Folkemer. She says that those individuals are people who want to leave facilities, can live successfully in the community with appropriate housing and services, and can make the transition only with MFP support.

“Careful evaluation of individuals in facilities, and careful attention to their needs after they leave, is essential,” says Ms. Folkemer. “Nursing home residents are very heterogeneous. Many people come for short stays and leave on their own. Many others come at the very end of their lives.”

Even among people who have been in the facility and on Medicaid for 180 days, which was the previous requirement, or for 90 days, which is the new requirement, Ms. Folkemer says that there is great diversity in family supports, ability to adapt emotionally and physically to a changed living arrangement, and many other things.

“MFP is all about choice for individuals. The benefits of the program will be individuals living and receiving services in settings that they prefer to nursing homes,” says Ms. Folkemer.

As more individuals benefit from MFP, additional capacity may become available to support other

persons with disabilities in the community. “In many ways, the expectation is that the financial support from MFP will help to build up an infrastructure that extends beyond MFP beneficiaries themselves,” says Ms. Folkemer.

One of several strategies

MFP is only one of several strategies states are putting in place to support choice by individuals as to the setting in which they live and receive care. “MFP provides significant financial support for change, but it is focused only on one group of individuals with needs,” says Ms. Folkemer.

The goal is for Medicaid to provide a better balance of long-term care options for individuals. Institutional services will become

“less dominant, and part of a broader array of services available to persons with care needs,” says Ms. Folkemer. “States have been working on this issue for at least a quarter of a century, through home and community-based services waivers and Medicaid state plan services.”

The challenge is to find ways to reach the people most at risk of going to institutions, and then provide them with the necessary supports to avoid this.

“If the state wants to balance its long-term care service delivery system rather than just add more people to its system, it must make sure that it identifies individuals who don’t want to enter a nursing home, but who are likely to enter one shortly — and offer them services that can help them stay out,” says Ms. Folkemer. “This is not an

easy thing to do; I predict states will find better ways to identify those people.”

Also, most Medicaid nursing home stays start with a Medicare-funded stay after a hospitalization. Therefore, finding ways to move individuals from hospitals to short-term nursing homes stays, and back to home, is important.

“This can’t be done by Medicaid alone; Medicare and Medicaid will need to work together on this, and that’s not easy either,” says Ms. Folkemer. “There will be more attempts by states to make the Medicare/Medicaid funding and service delivery connections more productive.”

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New options, requirements for preventive care

While some “front runner” Medicaid programs have made expansion of preventive care a priority to improve quality of care and reduce costs, most have only started to look at these possibilities. “Utilization rates remain low for preventive services that are very cost-effective and have been recommended for years,” says **Georges C. Benjamin**, MD, executive director of the American Public Health Association.

Health reform presents some concrete opportunities to help states to move forward with these initiatives. “There is language in the health reform bill that promotes quality improvement across the clinical spectrum,” says Dr. Benjamin. “Medicaid and Medicare are both required to improve the quality of their programs.”

An August 2009 Government Accounting Office study, *Concerted Efforts Needed to Ensure Beneficiaries Receive Services*, pointed out that additional efforts were needed to

strengthen the receipt of needed preventive services to beneficiaries.

“We actually know a lot about the benefit of preventive services,” says Dr. Benjamin. “Overall, we know that even modest degrees of cost-sharing result in reductions in utilization of preventive services. We also know that only half of the population receives the recommended preventive services.”

In December 2009, the Washington, DC-based National Committee for Quality Assurance released a Medicaid Managed Care Toolkit, in an effort to give Medicaid managed care plans better ways to improve the quality of their programs.

The U.S. Preventive Services Task Force, the Advisory Committee for Immunization Practices, and the Community Services Task Forces are three federal advisory groups that are used to define the evidence base for preventive services.

“These groups look at the science

around how well they work and their effectiveness,” says Dr. Benjamin. “There is compelling evidence that better care coordination using medical homes and similar models of comprehensive care teams results in better health outcomes for people who have medical conditions.”

Coverage is inconsistent

For children in the Medicaid program, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service provides screening for a range of potential medical problems. It requires that the program provide referral and treatment for any issues that need correction.

“EPSDT is designed to address the needs of low-income children who have a higher incidence of low birth weights, developmental delays, and medical problems,” says Dr. Benjamin. “As one example of this higher risk, as many as 80% of children in foster care are found to have

medical problems.”

Vision screening is an example of a procedure that identifies early problems, thereby preventing blindness and improving school performance, with a cost savings up to \$15,000 per quality adjusted life year, says Dr. Benjamin.

For adults, coverage of preventive services in the Medicaid program is inconsistent across states. “This is because many prevention benefits are considered an optional service,” says Dr. Benjamin.

The Affordable Care Act will require states to provide comprehensive Medicaid coverage for counseling and pharmacotherapy for tobacco cessation by pregnant women. It prohibits cost-sharing for these services. “Tobacco use during pregnancy results in several problems for both mother and baby. This will improve both pregnancy and maternal outcomes,” says Dr. Benjamin.

The law gives states the option to include diagnostic, screening, preventive, and rehabilitation services graded “A” or “B” by the U.S. Preventive Services Task Force in their Medicaid program benefits, without cost-sharing requirements.

For adults, it authorizes all immunizations and their administration recommended by the Advisory Committee on Immunization Practices. “States that cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, will receive an increased FMAP of one percentage point for these services,” says Dr. Benjamin.

Missed opportunities

The August 2009 GAO study reviewed both child and adult preventive services.

“It found that on certain measures, states were not performing as well as expected,” says Dr. Benjamin. “For example, as many as 40% of children did not get the required well-baby check. For adults, preventable opportunities were being missed.”

The Washington, DC-based Partnership for Prevention looked at what increasing prevention could do to improve the nation’s health. “It found that increasing the use of five preventive services would save 100,000 lives each year,” says Dr. Benjamin. Here are other key findings:

- 45,000 additional lives would be saved each year if the number of adults who take aspirin daily to prevent heart disease was increased to 90%. “Today, fewer than half of American adults take aspirin preventively,” notes Dr. Benjamin.

- 42,000 additional lives would be saved each year if the percentage of smokers who are advised by a health professional to quit, and are offered medication or other assistance, was increased to 90%. Today, only 28% of smokers receive such services.

- 12,000 additional lives would be saved each year if the percentage of adults 50 and older who are immunized against influenza annually was increased to 90%. Currently, the percentage is just 37%.

The Washington, DC-based Trust for America’s Health and the

New York City-based New York Academy of Medicine found that an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save over \$16 billion annually within five years.

“This is a return of \$5.60 for every \$1,” says Dr. Benjamin. “In addition, out of the \$16 billion, Medicare could save more than \$5 billion, Medicaid could save more than \$1.9 billion, and private payers could save more than \$9 billion.”

Preventive services in Medicaid are “in a variety of stages,” says Dr. Benjamin. “States with long-term managed care programs have been doing quality for some time,” he says. “EPSDT is uniform across the country. However, there are differences in performance. Adult access to preventive services likewise could be improved.”

The August 2009 GAO study found that access to prevention benefits wasn’t consistent across state Medicaid programs. “The report recommended that [the Centers for Medicare & Medicaid Services] and the states provide better oversight to ensure these benefits are received,” says Dr. Benjamin. “Budget cuts and the recession have had an uneven effect across the nation. It is too early to see how many of the states will benefit from the enhanced FMAP to expand prevention coverage.”

Contact Dr. Benjamin at georges.benjamin@apha.org. ■

Many children are going without coverage needlessly

Children with private health insurance are more than six and a half times as likely to lose coverage in the three months after one or both of their parents loses a job, compared to children whose parents remain employed, according to researchers from the Child Policy

Research Center at Cincinnati (OH) Children’s Hospital Medical Center. Their study, *The Impact Of Parental Job Loss On Children’s Health Insurance Coverage*, published in the July 2010 *Health Affairs*, says that for every 1,000 jobs lost, 311 privately insured children lose health

insurance coverage. The poorest and most vulnerable privately insured children were especially likely to lose coverage.

Gerry Fairbrother, PhD, the study’s lead author and associate director of the Child Policy Research Center, wasn’t surprised by

the findings. “I expected it would be the case, but the first time it’s been shown nationally with a high-quality database,” she says.

Dr. Fairbrother says that since the children were privately insured, it’s possible that at least some of their families might not have had previous contact with the public assistance system. Therefore, they might have been unaware their children were eligible for coverage.

She says that state Medicaid programs should look at ways to provide more aggressive outreach if they know a plant is closing, and provide additional public service announcements about availability of public coverage and eligibility requirements.

While privately insured children lost coverage when a parent lost a job, publicly insured children lost coverage at fairly high rates regardless of whether there was a job loss. This was not surprising either, says Dr. Fairbrother.

“This is due to high rates of churning in public insurance, which is not tied to employment, but is tied to income,” says Dr. Fairbrother. “That high level persists whether or not parents lose a job.”

Dr. Fairbrother says that it is not a foregone conclusion that the problem of children losing coverage,

whether they are privately or publicly insured, is going to be solved under health reform. “Whoever administers the [health information] exchanges (HIEs) will have to be aggressive in making sure people don’t fall off the rolls,” she says.

If a parent in the HIEs loses a job, it could be that the family becomes eligible for Medicaid. “There would be an issue of getting that word out and making sure members of the family remained covered,” says Dr. Fairbrother. “If we need education now, we are certainly going to need it under health reform, which brings in a new set of complexities.”

More outreach needed

“Since employer-based insurance is the most prevalent form of coverage in this country, it’s no surprise that children lose coverage when a parent loses a job,” says **Tricia Brooks**, a senior fellow at the Georgetown University Center for Children and Families in Washington, DC. “Unemployed parents simply can’t afford COBRA coverage, and many of these families have never used public insurance programs.”

Even though large majorities of people know Medicaid and the Children’s Health Insurance Program

exist, there is confusion about who is eligible and how to apply. “Like sales, marketing and customer service in business, outreach and application assistance for public coverage programs [is] needed on a continual basis to ensure that eligible individuals and families get enrolled and stay enrolled,” says Ms. Brooks.

Ms. Brooks notes that a number of states deploy rapid response teams when major employers close down. Counseling and education is provided to help displaced workers access training, seek new work, and apply for other public assistance.

Workers who lose employment under other circumstances don’t necessarily get that level of personalized assistance, however. “Many could be reached through unemployment offices and one-stop job centers,” says Ms. Brooks. “Providing information, as many of these centers and agencies do, is a start. More deliberate outreach and application assistance is better.”

Unfortunately, families and individuals need the most help during downturns in the economy, which restricts state budgets. Resources for administration of public programs are scarce, and agencies have to do more with less.

“State financial support for outreach and application assistance is hard to come by,” says Ms. Brooks. “We need to institutionalize the role of outreach and application assistance, and boost it in times of high need.”

Streamlining the application process can remove barriers to enrollment, such as minimizing the paperwork that is required. “These actions not only improve enrollment, but also increase administrative efficiency,” says Ms. Brooks. “This allows states to dedicate more resources to health care services.”

Contact Ms. Brooks at (202) 365-9148 or pab62@georgetown.edu and Dr. Fairbrother at (513) 636-0189 or Gerry.Fairbrother@cchmc.org. ■

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North Carolina uses population management tack

Community Care of North Carolina, an enhanced Primary Care Case Management (PCCM) program, uses a “population management” approach to manage high-cost Medicaid clients.

Evidence-based guidelines are used, with outreach and care management targeting the patients with the highest risk and cost. These individuals receive disease management, team-based care, and treatment of acute episodes and prevention.

“Care management is outcome-focused, and monitors the population and service delivery system using meaningful information,” says **Denise Levis Hewson**, RN, BSN, MSPH, the program’s director of clinical programs and quality improvement. Primary care providers are given information after quality audits identify gaps in care, such as a diabetic who has not had an annual foot exam.

ID affected patients

One challenge for a successful care management program is determining which subsets of the enrolled population will benefit from the care management interventions. “Identifying those impactable patients is an ongoing skill-building process,” says Ms. Hewson.

Reports are generated from administrative claims data to help the primary care providers, care managers, and networks identify potential individuals who could benefit from targeted interventions.

“An effective population management approach builds in the patient self-management component through member education and care support,” says Ms. Hewson. “In North Carolina, we have built our enhanced PCCM program around the medical home model.”

This means that the networks

work in concert with primary care providers to manage the high-risk and high-cost patients. “This approach aims to increase the number of individuals with chronic conditions that are able to manage their disease, and lower over time the percentage of high-risk and high-cost patients in the population,” says Ms. Hewson. “It is important to engage primary care providers in the development and implementation efforts. They have, and continue to be, the ‘leaders’ of our program.”

Care management processes and interventions are standardized. “This enables the program to share best practices, establish meaningful expectations, and monitor and evaluate program activities,” says Ms. Hewson.

Once identified, recipients who agree to participate are given a comprehensive health assessment. This covers medical conditions, interventions, and goals.

If a patient in the aged, blind, and disabled population has two or more chronic conditions, including mental health, he or she is considered high-risk. The patient is defined as “unstable” by meeting two or more of the following criteria:

- one or more inpatient admissions within the past six months;
- three or more ED visits within the past 6 months;
- eight or more prescriptions over the past month, or 24 over three months;
- three or more outpatient providers over six months;
- no primary care physician visit within the past year;
- two Activities of Daily Living deficits requiring hands-on assistance.

Patients meeting these criteria are tracked in the central data repository in Community Care’s Informatics Center. “All 14 networks have access to available and appropriate patient

information for those individuals receiving care from the participating practices/primary care providers,” says Ms. Hewson.

Self-management is key

“Transitional care is designed to ensure the coordination and continuity of health care during the movement between health care practitioners and settings, as the patient’s condition and care needs change during the course of a chronic or acute illness,” says Ms. Hewson. “Transitional care is essential for persons with complex care needs.”

For instance, older adults who suffer from a variety of conditions often get health care services in different settings to meet their many needs.

“Most transitional care begins while a patient is hospitalized and before discharge planning,” says Ms. Hewson. “The network care managers aim to see the patient before discharge from the hospital. This develops a rapport and increases the likelihood that they will wish to participate in the program after discharge.”

Care managers work with patients to promote self-management skills. “These are essential to improve patient outcomes,” says Ms. Hewson. Here are some of the things they do:

- facilitate interdisciplinary collaboration across transitions;
- encourage the patient and caregiver to play a central and active role in the formation and execution of the plan of care;
- promote direct communication between the patient or caregiver with providers;
- achieve medication reconciliation. This is done through consultation with the network pharmacist, the hospital, the primary care physician, the specialists, and the patient or caregiver.

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“Medication reconciliation is a critical component of transitional care,” says Ms. Hewson. “The network care manager may be the only person with all the data needed to put the medication puzzle together.”

Duals are next step

These same population management strategies are now used to manage dual-eligibles. “The networks and participating practices serving Medicaid recipients are also serving the duals and the straight Medicare population,” says Ms. Hewson. “It was a natural next step to explore opportunities to manage additional populations with our community-based statewide infrastructure.”

Over the past several years, the Community Care of North Carolina program has consistently saved the state over \$100 million a year. The state’s budget shortfall has put additional pressures on the program, however.

Efforts have increased in the areas that have achieved the highest cost

savings. These are preventing readmissions, increasing the use of generic prescribing, mental health integration efforts, and preventing unnecessary emergency department utilization.

“There are expectations for the program to continue to achieve savings, and to even achieve greater savings,” says Ms. Hewson. We will continue to look at populations to manage within our model.”

Contact Ms. Hewson at (919) 745-2363 or dlevis@n3cn.org. ■

Dementia patients’ spouses at higher risk

Husbands or wives who care for spouses with dementia are six times more likely to develop the memory-impairing condition than those whose spouses don’t have it, according to the results of a 12-year study led by Johns Hopkins, Utah State University, and Duke University.¹

A few small studies have suggested that spousal caregivers frequently show memory deficits greater than spouses who aren’t caregivers. However, none examined the cognitive ability of caregivers over time using standard, strict criteria to diagnose dementia.

A study examined 1,221 married couples age 65 and older who were part of the Cache County (Utah) Memory Study, which began in 1995.

In the sample of 2,442 married people, the researchers diagnosed 255 individuals with dementia and discovered that individuals whose spouses had already been diagnosed were six times more likely to develop the condition themselves than those without an affected spouse.

REFERENCE

1. Norton MC, Smith KR, Ostbye T, et al. Greater Risk of Dementia When Spouse Has Dementia? The Cache County Study. *J Am Geriatr Soc* 2010;58:895-900. ■

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