State Health Watch
Vol. 17 No. 11 — The Newsletter on State Health Care Reform — November 2010

AHC Media LLC

Now is "absolutely the time" for Medicaid payment reform

While surging Medicaid enrollment and plunging revenues are making headlines, a less visible issue is how states pay for health care. However, this may be the single best answer to containing costs under health care reform, according to a May 2010 policy brief from the Center for Health Care Strategies (CHCS) in Hamilton, NJ.

The brief, *Payment Reform: Creating a Sustainable Future for Medicaid*, reports on redesigning Medicaid payment policies to increase the value of care being purchased.

States are taking several different approaches to payment reforms. For some states, such as New York, the starting point was an analysis of existing payment methodologies and payment levels in both fee-for-service and Medicaid managed care, and in both the acute and long-term care sectors.

Eighty percent of Medicaid funding is still fee-for-service. "Fee-for-service payments are the building blocks of reform. Rationalizing these payments provides both an immediate opportunity to contain costs and enhance quality," says **Deborah Bachrach**, JD, a senior program consultant with CHCS. "It is also the foundation of more expansive

*See **Payment reform** on page 2*

Pennsylvania Medicaid saves billions with mandatory managed care

The number of people in Medicaid's managed care plans is growing, but more of these new enrollees are children and their parents, rather than the higher-cost aged, blind, and disabled population. In 1997, Pennsylvania began to implement a program called HealthChoices and move people on Medicaid into mandatory managed care.

"I think that including the aging, blind, and people with disabilities was really an advantage to us," says **Michael Nardone**, acting secretary of public welfare for the department of public welfare's office of medical assistance programs. "Some states have not necessarily gone forward with some of the more complex populations, but that is something that Pennsylvania had the foresight to do early on."

HealthChoices saved the state $2.7 billion over a five-year period, according to a 2005 report by the Falls Church, VA-based The Lewin Group, *Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-*

Fiscal Fitness: How States Cope

*See **Fiscal Fitness** on page 3*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

Back issues of ***State Health Watch*** may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *State Health Watch,* P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.
Subscription rates: $399 per year. Add $17.95 for shipping & handling. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $67 each.
Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.
(GST registration number R128870672.)

Editor: **Stacey Kusterbeck**, (631) 425-9760, staceykusterbeck@aol.com.
Managing Editor: **Karen Young**, (404) 262-5423, karen.young@ahcmedia.com.
Executive Editor:
Russ Underwood, (404) 262-5521, russ.underwood@ahcmedia.com.
Production Editor: **Neill L. Kimball**.

AHC Media LLC

Cover story

Continued from page 1

reforms, such as bundled payments and medical homes."

Timing is right

Ms. Bachrach says, "Now is absolutely the time for states to be evaluating their payment policies and initiating payment reforms. Across-the-board rate cuts may save dollars, at least in the short run, but they are not reform."

These cuts potentially undermine access and quality, as well. "Sound payment policies are essential to addressing current budget shortfalls and to prepare for the enrollment into Medicaid of 15 to 20 million more people starting in 2014," says Ms. Bachrach.

In addition, Ms. Bachrach says that Medicaid's ability to influence the cost and effectiveness of care "will be enhanced to the extent it collaborates with other payers. And Medicaid will find it difficult to participate in multipayer initiatives unless it has first adopted sound payment policies."

Several demonstrations are authorized in health care reform legislation to test out new methods of payment, aligned with collaborative care models.

"This is a really exciting opportunity for states to take advantage of," says **Allison Hamblin**, CHCS' director of complex populations. "Current Medicaid payment methodologies limit states' abilities to pay for care coordination activities among providers. That is a challenge we are facing in many of the pilots we are supporting in this area."

The hope is that the demonstrations will give states the ability to test novel ways to finance these models of care. "These new financing and care delivery options offer the potential to much more effectively manage care for complex populations," says Ms. Hamblin.

However, Ms. Hamblin notes that many states are in hiring freezes. With the many demands of preparing for expansion, they may not have the resources to fully capitalize on these opportunities to test new approaches.

"The real challenge is going to be figuring out how to implement expansion in a way that most effectively meets the needs of the newly covered populations. Many will have multiple physical and behavioral health conditions," says Ms. Hamblin. "Pursuing one or more of the demonstration opportunities will enable states to get a head start on developing the care delivery and payment systems required to serve millions of new beneficiaries come 2014."

New opportunities

Health care reform, says Ms. Bachrach, "provides tremendous opportunities for state Medicaid agencies, with its focus on chronically ill patient populations and integrated care models. You can expect Medicaid agencies to take full advantage."

One example is the law's provision for health homes. States will be eligible for a 90% federal match for health home services provided to individuals with serious behavioral health problems or two chronic conditions such as asthma, diabetes, obesity, and heart disease.

Covered services include many that are key to managing the care of these high-need, high-cost patients, but have not traditionally been covered by state Medicaid programs, says Ms. Bachrach. These include care coordination and health promotion, post-discharge community follow-up, patient and family support, and referral to community and social support services.

"Several states are considering

how this provision might be combined with the Affordable Care Act's support for community health workers and incentives for Medicaid patients who adopt healthy behaviors that have been demonstrated to prevent chronic diseases," says Ms. Bachrach. There is also substantial state interest in integrated funding for dual-eligibles.

"All of these populations are among the most medically complicated and costly populations for state Medicaid programs," says Ms. Bachrach. "States are dedicated to developing more effective payment and care models. The overarching challenge, however, for state Medicaid agencies is staff shortages, making development of even critical new programs difficult."

Brian Osberg, Minnesota's state Medicaid director, says that health care reform "is an opportunity for us to advance our service and payment reform activities that we already started here, and a chance for Medicaid to participate in some of these initiatives."

The state is applying for an advanced primary care demonstration involving Medicare's participation in Minnesota's health care home arrangement. "We have a multipayer model here," says Mr. Osberg. "It is important that we have critical mass to make it work for providers, as opposed to having Medicare doing its own separate demonstration."

Minnesota is looking to implement new models of payment for episodes of care, both for Medicaid and Medicare. The health care reform law provides 90% federal funding for the health care home fee arrangement. "We will be well positioned to take advantage of that in January 2011," says Mr. Osberg. "We will also consider global payment demonstration models for safety net hospitals and pediatric accountable care organizations, consistent with what we want to advance here in Minnesota."

There is also a directive from the state legislature to develop an accountable care organization demonstration by next year. "There are a lot of things in the law that allow for flexibility around service and payment reform that we will certainly take a close look at," says Mr. Osberg. "The new law provides possibilities, and we are going to examine those possibilities."

A pay-for-performance arrangement for Medicaid is already in place, as part of the Bridges to Excellence program initiated by large employers. "So, we are part of that here, but we also want to eventually look at expanding those incentives to our own clients," says Mr. Osberg. "At one point, we had money to do that. Unfortunately, it was a victim of the budget deficit, so we lost those incentives."

Minnesota Medicaid already has approval from the Centers for Medicare & Medicaid Services to do a health care home payment arrangement. "We will be paying a care coordination fee. That is on its way, and the next stage is to develop a total cost of sharing arrangement," says Mr. Osberg. "Providers who see our clients have the incentive to manage the entire cost of care. That is the next level of payment reform that we want to focus on."

Contact Ms. Bachrach at (212) 866-0801 or DBachrach@BHSstrategies.com, Ms Hamblin at (609) 528-8400 or ahamblin@chcs.org, and Mr. Osberg at Brian.Osberg@state.mn.us or (651) 431-2189. ■

Service Program.

Since 2005, significant savings have continued to accrue and are projected to continue. The rate increases for Pennsylvania's mandatory managed care plans have been one-half of the medical cost trend in the managed care zones for the five-year period ending Dec. 31, 2009.

"We've had a pretty long history of managed care in Pennsylvania, so we have a fairly mature program," says Mr. Nardone, who has been the state Medicaid director since early 2007, but was in the provider community when HealthChoices was first implemented. At that time, both consumers and providers were voicing concerns that this change would limit a consumer's choice of providers, or their access to care.

"At that point in time, managed care was still not as pervasive in the Medicaid world. But if you were to talk to our consumers now, you would find that we have overcome those concerns," says Mr. Nardone. "Stakeholders are now generally supportive of managed care in Pennsylvania, but that was something we had to develop over time."

Outcomes are achieved

Support was achieved by involving stakeholders in the managed care program's development. Other key factors included giving providers enough time to make a smooth transition to the new program and having the necessary infrastructure in place.

"It isn't that you just turn Medicaid over to Medicaid managed care and then let managed care plans go off and do their own thing," says Mr. Nardone. "It isn't enough to just go to managed care. We've really had to manage the managed care program to ensure we get the necessary outcomes and make sure the managed care plans are tasked to achieve them."

This is done in a variety of ways, including using pay-for-performance initiatives. "That is one of the things I'm particularly proud of," says Mr. Nardone. "Paying managed care plans to reach certain care objectives is really the strategy we use, to be sure we are maintaining a cost-efficient program, while at the same time, achieving the type of

health outcomes that we want to see for our consumers."

The infrastructure needed for this, though, was something that had to evolve over time. "It wasn't something that was in place on day one. You need to develop staff capacity; that is something that takes some time," says Mr. Nardone.

Although the goal from the beginning was to take managed care statewide, it was rolled out in the Philadelphia area first. Pittsburgh and the surrounding counties came next, and nine years ago, a third zone was developed for mandatory managed care in the south central, or "Lehigh/Capital" zone.

However, Pennsylvania's managed care model may not have been an ideal model in the state's rural areas. "Difficulties in establishing sufficient provider networks, and the feasibility of compliance with the requirements that federal regulations impose on managed care organizations, compelled serious consideration of an alternate method for delivering Medicaid services in rural Pennsylvania," explains Mr. Nardone.

Ultimately, the department chose an enhanced primary care case management (PCCM) model with a disease management component. Known as ACCESS Plus, the PCCM program operates under Pennsylvania Medicaid's fee-for-service system.

The PCCM program is operational in 42 of Pennsylvania's rural counties. Recipients residing in 25 of these 42 counties also have a choice between managed care and PCCM, as ACCESS Plus and voluntary managed care plans operate side by side.

Performance is monitored

In Pennsylvania, the elderly and disabled represent about one-third of the Medicaid population, but consume about two-thirds of Medicaid resources. "Each state has its own statistics on this, but it is the high-cost patients that do consume a significant portion of resources," says Mr. Nardone. "So, if we can better manage their care and do some better preventive services up front, we can bend the cost curve in terms of better managing care."

A two-pronged strategy is used to pay HealthChoices managed care organizations (MCOs). "We have certain federal requirements around what we have to pay the MCOs at minimum," says Mr. Nardone. "We basically start at that point, and the managed care entities can earn additional payments based on their performance."

These pay-for-performance initiatives are based on 12 Healthcare Effectiveness Data and Information Set measures, including cholesterol management for patients with cardiovascular conditions, glucose screening for people with diabetes, frequency of prenatal visits, and lead screening for children. "We use it to monitor the performance of the MCOs, but it also has an impact on their bottom line. They can earn up to 2.5% of their capitation related to these measures," says Mr. Nardone. "We are pretty proud of that aspect."

A similar set of performance measures are used to evaluate the disease management/PCCM vendor. In nine of the 12 quality measures, significant improvement has been seen since the pay-for-performance program was established in 2005.

"Again, it's not just about contracting with a managed care entity. You have to manage that process," says Mr. Nardone. "I think our pay-for-performance has set up a pretty good structure to ensure good quality and be cost-efficient."

Cost increases are faced

"Because of the infrastructure we have built, we have been able, up to this point, to forestall some of the draconian cuts we have seen in other states," says Mr. Nardone. "Still, this is a real challenge in an environment where revenues are declining or stagnant. Even though we are managing the program as well as we can, there are cost increases."

The FY 2010 budget includes a 4% increase in the capitated, per-member, per-month rate paid by the state for the 1.2 million enrollees in managed care. "We have had to reduce hospital payments, but not on the magnitude of some other states," says Mr. Nardone. "At a time when revenues are stagnant or declining, that is still a cost that we have to absorb within the budget. That is why there is still pressure on the Commonwealth and the department budget."

Mr. Nardone says, however, that the state is "pretty well positioned on health care reform. We think that this will actually be a potential net savings to Pennsylvania through 2018."

The drug rebate provisions included in health care reform will bring significant advantages to the state. "We have tried to carve out the pharmacy benefit but have not been able to," notes Mr. Nardone. "So, the provision that enables us to collect federal rebates for prescription drugs provided through MCOs helps us significantly. It is a budget savings and something we are counting on for the next fiscal year. We are putting the pieces in place so we can aggressively take advantage of that provision."

Pennsylvania also has programs that provide coverage for single adults. There is a general assistance program for chronically disabled adults who otherwise are not eligible for Medicaid. An adults basic program covers individual and family members up to 250% of the federal poverty level.

"These are folks who would be

considered 'newly eligible' under health care reform. So, when the provisions kick in, in 2014, we should be a good position to take advantage of the federal matching funds available for those individuals," says Mr. Nardone.

There are currently 40,000 individuals in the programs. "So, to the extent that we will now receive 100% federal financial participation [FFP], that is additional money to the state," says Mr. Nardone. "If a state doesn't have a state-only program for low-income individuals like we do, they will not see the benefits that we will. It could be a cost to them, because they have to pick up the state share."

Another area of interest is the rebalancing incentive for long-term care. "We are below the threshold and are potentially eligible for that funding," says Mr. Nardone. "Moving towards more community-based services for folks in nursing homes is something we have been pursuing for a number of years. The ability to get enhanced FFP for those services is something we can take advantage of."

The state will incur costs to upgrade or replace its eligibility systems and administrative costs for drawing down the federal drug rebates for the MCOs. "As we plan our health care reform efforts, our budget folks are at the table. They are ensuring, to the extent there are additional resources required, that we are building that into our budget," says Mr. Nardone. "But when we look at the broader picture, I think the potential savings will be greater." ■

Medicaid overutilization a concern? Deny, reduce, or bundle payments

A growing number of states are implementing policies to deny or reduce payments for hospital-acquired conditions or potentially preventable readmissions. Exactly how much does this save?

"In most cases, the data is just becoming available as to the care and cost impacts of these reforms," says **Deborah Bachrach**, JD, a senior program consultant with the Center for Health Care Strategies in Hamilton, NJ. "However, states report that these reforms are already producing better data." This is critical to measuring quality and outcomes, as well as cost-effectiveness.

"We still largely live in a fee-for-service environment, where we reward more activity," says **Sandeep Wadhwa**, MD, former chief medical officer with the Colorado Department of Health Care Policy and Financing. "For a long time, that's been viewed as actually promoting safety, but there are disadvantages to just paying for things."

One is that overutilization is encouraged. "We should really reserve the hospital for when the benefits clearly outweigh the risks," says Dr. Wadhwa. "We are developing payment policies that are both disincentives as well as incentives."

Inadequate payment system

Jed Ziegenhagen, the department's rates manager, says that the current health care payment system is "generally inadequate. It is not fair to the taxpayer, the provider, or the patient."

The Colorado HealthCare Affordability Act provided a number of reforms to the Medicaid health care system. This includes updating and modernizing hospital payment methodologies and providing an incentive pool for hospitals that meet performance targets in the areas of reducing readmissions, patient safety, tobacco use, and unnecessary emergency department utilization.

Hospitals will no longer be paid for same-day readmissions. "But, there is also some bonus money for bringing down your readmission rate, which is almost pure margin," says Dr. Wadhwa.

The concept of a bundled payment for a single admission was part of the Medicare Acute Care Episode (ACE) demonstration in 2009. "What's being talked about in health care reform is a warranty for health care, with a payment for an entire episode. The doctor and hospital bear the risk if a hip replacement or asthma patient comes back and is readmitted," says Dr. Wadhwa. "There are grants in the law around bundled payments involving hospitals. Many of them will include readmission as one payment."

Dr. Wadhwa says that health care reform's inclusion of quality initiatives, including preventing avoidable admissions, "sends a message of validation. There are so many ways our partners are hearing about this. That helps to legitimize that we're not off on some tangent. It's an exciting time to be promoting a system that is promoting efficiency, as well as patient safety."

In addition, the Center for Improving Value in Health Care (CIVHC) was established, with a broad, multipayer focus. "This will benefit Medicaid as one of many Colorado payers," notes Mr. Ziegenhagen.

One of the target areas of CIVHC is payment reform designed to reward outcomes rather than volume. An important tool to support that aim is a statewide all-payer claims database, to be administered

by CIVHC. This will provide information and transparency in health care pricing, utilization, and value. "Bringing that information to the health care marketplace will drive changes in behavior, including changes in payment rates and methodologies," says Mr. Ziegenhagen.

In addition, the governor's budget included two items connected to payment reform. One is the Coordination of Payment and Payment Reform, which packages a number of payment-related items. This includes a directive to the department to examine and suggest reforms to payment mechanisms for physicians, long-term care waiver services, and dual-eligibles.

"The department has an active solicitation for a contractor to assist it in implementing part of this package and is drafting language to purchase additional services," says Mr. Ziegenhagen.

Colorado's Accountable Care Collaborative (ACC) uses a model of community-driven accountable care to measure and improve health through care coordination and client management. "Included are possible payment incentives for each of the seven regional care coordination organizations that meet specified performance targets," says Mr. Ziegenhagen.

While the ACC is primarily a delivery system reform, the belief is that payment reform and delivery system reform complement each other.

"At its essence, payment reform is about providing financing and incentives for changes in behavior in the health care system," says Mr. Ziegenhagen. "Payment reform will be effective only if the learning and support environment in a robust health care delivery system enables the changes that we are trying to incentivize through payments."

Mr. Ziegenhagen adds that some of the components of federal health care reform will provide potential funding to make changes that are necessary for the sustainability of Colorado's Medicaid program.

"While there are many changes in the federal health care reform legislation, few were brand new," says Mr. Ziegenhagen. "We have been working on some projects that are aligned with what came out of the federal health reform legislation. The department is working to assess which of the numerous grant funding and other opportunities in health care reform will best pair with our homegrown efforts."

Contact Mr. Ziegenhagen at (303) 866-3200 or jed.ziegenhagen@state.co.us. ■

Get ready for complex needs of new Medicaid population

Covering childless adults could be more costly than anticipated, because this population had more complex needs than expected, according to some states surveyed in a July 2010 report from the Washington, DC-based Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences*.

Robin Rudowitz, MPA, one of the report's authors, says that in talking to states about their experiences, she learned that two-thirds of uninsured adults below 133% FPL are without dependent children.

"Many of them are very low-income — under 50% of the poverty level. When you look further, you see many are either at the lower end or the higher end of the age spectrum," says Ms. Rudowitz. "With the 55-to-64 group, you know they are more vulnerable to health risks."

A number of states have already expanded coverage to childless adults or expanded coverage further up the income scale, either through Medicaid or state-funded programs. Currently, 27 states offer no coverage for childless adults, according to a 2009 survey conducted by KCMU with the Center on Budget and Policy Priorities, also based in Washington, DC. Five states offer coverage comparable to Medicaid, 15 provide more limited benefits, and four offer premium assistance to a limited population of adults.

"When we look at the group below 133% FPL, which are all newly eligible for Medicaid, one in six are in fair or poor health. Many have chronic conditions," says Ms. Rudowitz. "If the person is uninsured, he or she has poor access to care."

Uninsured adults at or below 133% FPL are a diverse group, including many sick individuals for whom any coverage is currently unavailable, according to an April 2010 policy brief from KCMU, *Expanding Medicaid Under Health Reform: A Look at Adults at or Below 133% of Poverty*. Many have problems accessing health care, and about one-third of them have been diagnosed with a chronic condition.

Test new approaches

There is information to be gleaned from states that have expanded coverage, either through state basic health plans or through waivers. "There are quite a few states that have already expanded coverage to optional populations to some extent," says **Allison Hamblin**, director of complex populations for the Hamilton, NJ-based Center for Health Care Strategies (CHCS).

A significant subset of the expansion population will have a complex range of health needs, including high rates of mental illness and substance abuse, according to a CHCS brief, *Covering Low-Income Childless*

Adults in Medicaid: Experiences from Selected States. The brief's findings are based on 10 states with existing programs for low-income childless adults.

In addition, costs for the expansion population on average are likely to be greater than costs for parents currently enrolled in Medicaid, but less than costs for adults with disabilities.

"Looking at the utilization patterns and demographics, the picture is starting to emerge that the behavioral health and substance abuse needs among the expansion population will be similar to those of the aged, blind, and disabled population," says Ms. Hamblin.

Ms. Hamblin says that in light of this, "there is an incredible opportunity for states to test novel approaches to figure out how to manage care for their costliest populations. The need to have effective systems in place is going to be that much more important when there are 15 million new beneficiaries in the system. Many of them are likely to look like our complex patients that we are now working with."

For this reason, Ms. Hamblin says that state Medicaid programs should be using the time between now and 2014 to build capacity and test new strategies. "By putting some core elements of integrated care management in place today, states will be better positioned to meet the needs of the expansion population in 2014," she says.

Diverse population

"Because we're up to 300% FPL already, a lot of people who are going to be new folks for other states are already in our program," says **Philip Poley**, chief operating officer for MassHealth.

"When you are talking about childless adults at certain income levels, you are talking about people who might be homeless or struggling with substance abuse problems," says Mr. Poley. "In our experience, it's kind of hard to reach these people and ensure consistent care."

Mr. Poley says that particularly in the upper-income ranges, other childless adults didn't fit this profile at all. Many were working people who just didn't qualify previously for benefits. "Those are folks who just didn't know there was insurance out there for them. We really had to undertake a multifaceted effort to reach them," says Mr. Poley.

The state's Commonwealth Health Insurance Connector Authority, which is similar to the health insurance exchanges that states are required to set up under health care reform, did a major outreach effort. This included partnerships with the Boston Red Sox, health clubs, and organizations that were likely to have individuals who fit this demographic profile.

Make consequences clear

"The other thing that we found out is that somebody may get a piece of information, but they might have to hear it a number of times from lots of different sources before they determine that 'This is real, this applies to me, and I need to take some action,'" says Mr. Poley.

The fact that there was a statewide mandate gave the state the ability to send the message that if individuals didn't obtain coverage, there would be a consequence. "That allowed us to make clear to people that they had to pay attention," says Mr. Poley. "There was also a direct mail campaign, which hit the whole state."

Once the individuals in the expansion populations were enrolled, Mr. Poley says that, "It's the same experience that you have with Medicaid. Some populations are very stable and maintain good connections with the health care system and with the eligibility system, and some don't."

Mr. Poley adds that while some of the expansion population "fits a non-stable life circumstance category, they are not a homogenous group at all. Some are just self-employed individuals who never had coverage before. So, a lot of it was education about health insurance generally and the need to participate in their own care. We had a very good take-up rate."

Before Massachusetts implemented health care reform, there was a high rate of insured and a high rate of individuals with employer-offered insurance. "So, when other states are trying to see if there's anything they can learn from us, perhaps there is, but it's also important to understand the context in which you are starting from," says Mr. Poley. "And those two things were important things in our favor."

There were some state-funded programs that gave benefits to undocumented people through the health safety net, and some immigrants who were legal but weren't covered by Medicaid, because they didn't meet the five-year requirement. "So, before we started health care reform, those were folks who already had an entrée to our system. We were starting from a very good place," says Mr. Poley.

Look at current programs

Mr. Poley says that to meet the needs of the Medicaid expansion population, looking at your existing programs that serve high-cost members is a good place to start. "While you certainly might see this new population bringing some additional high-cost members to the mix, I don't necessarily believe they are completely different in their profile," he says. "Each state is different. Medicaid programs might want to fine-tune their focus on the high-cost groups based on their own demographics."

MaineCare for Childless Adults

is a waiver program with a capped enrollment of 20,000 individuals at or below 125% of FPL. This population receives a comprehensive benefit package comparable to the Maine Medicaid program.

Trish Riley, director of the Governor's Office of Health Policy and Finance, says that demographics for childless adults below 100% FPL in Maine are 55% male with an average age of 40, 4% homeless, and 28% are unemployed. Half of the total costs are spent on hospitals and pharmaceuticals, with a per-member, per-month cost of about $430.

"Childless adults are a mixed group and include some very high-cost users," says Ms. Riley. "The group includes people with significant disabilities who are awaiting disability determination and Medicare eligibility."

Contact Ms. Rudowitz at (202) 347-5270 or RobinR@kff.org, Mr. Poley at (617) 573-1770 or Philip.poley@state.ma.us and Ms. Riley at (207) 624-7442 or Trish.Riley@maine.gov. ■

Vermont steps into a first-ever approach to manage duals

Vermont is looking to take an innovative Medicare waiver approach to advance integration of care for dual-eligibles — one that has never been done anywhere in the country.

Vermont already has two different 1115 waivers in place. One is the Choices for Care Long-Term Care Medicaid Waiver, which gives eligible individuals a choice of nursing home and home and community-based care.

The other is a Global Commitment to Health 1115 Medicaid waiver, which includes all Medicaid services except Children's Health Insurance Plan and long-term care. Both have been in place for five years and are coming up for renewal.

"We are asking CMS [the Centers for Medicare & Medicaid Services] for extensions on both," says **Brendan Hogan**, MSA, acting commissioner for Vermont's Agency of Human Services' Department of Disabilities, Aging and Independent Living. "We have been able to manage high-cost populations with both because of the flexibility we have in 1115 waivers, as they are research and demonstration waivers."

Without this flexibility, the expenditures for services would have been higher. "We believe we have been very efficient in operating the two waivers," adds Mr. Hogan. "That allowed us to avoid higher costs."

Better integration

The new approach involves integration of dually eligible individuals. "What we'd like to do on the dual-eligible front is for the state to act as the Medicare managed care entity," says Mr. Hogan. "That is extremely innovative and has never been done in the country before."

This would mean that the state would receive Medicare funds directly from the federal government and administer both Medicare and Medicaid programs for individuals who are dually eligible for both programs.

With other Medicare managed care plans, CMS contracts with a commercial health plan. "We do have some history with being a Medicaid managed care entity, under Global Commitment to Health," says Mr. Hogan. "Since 2005, Vermont has been a Medicaid managed care entity. We are exploring the possibility of doing the same for Medicare."

Vermont is currently the only state that acts as a Medicaid managed care entity. "With the duals approach, we want to add Medicare funding to that model," says Mr. Hogan. "The state already manages the care for the Medicaid side. If we were able to manage the funding and services through our existing networks on our Medicare side, we'd be able to integrate care in a better way."

Vermont is a recipient of the Hamilton, NJ-based Center for Health Care Strategies' Transforming Care for Dual-Eligibles grant. In working with other states, Mr. Hogan says that several have expressed interest in taking a similar approach.

"Specifically, we would like to work to enhance the community-based approach Vermont has had for years by adding Medicare funding to the mix and linking existing case management systems for severely and persistently mentally ill, developmentally disabled and elderly, and physically disabled Vermonters with our existing multipayer efforts," says Mr. Hogan.

Less expenditures

"The next step is for the Medicare waiver options to be brought forward by CMS," says Mr. Hogan. "We will have to work with CMS to negotiate this." However, Mr. Hogan says, the Center for Medicare and Medicaid Innovation that was established by health care reform is a very hopeful sign.

"We believe that health care reform has given us the opportunity for the coordination of the duals. We look forward to talking with CMS about whatever possibilities there may be under that new office," says Mr. Hogan.

Vermont's dual-eligible popula-

tion, which totals about 18,000, [is] "certainly a concern, like they are for every other state," says Mr. Hogan. "The dually eligible population are one of the frailest, but also one of the highest cost for both Medicare and Medicaid."

Ultimately, Mr. Hogan says he expects to see reductions in both Medicaid and Medicare expenditures, as well as better coordinated care for the beneficiaries. "I do see opportunities coming forward at the federal level; I am optimistic," he says.

Contact Mr. Hogan at (802) 241-2326 or brendan.hogan@ahs.state.vt.us. ■

Many children still falling off Medicaid

About 2 million children became uninsured in 2008, despite their ongoing eligibility for the Children's Health Insurance Program (CHIP), according to a new report from the Harvard School of Public Health, *Enrolling Eligible Children In Medicaid And CHIP: A Research Update*.

"The results were a bit of a mixed story of good news and bad news," says **Benjamin D. Sommers**, MD, PhD, the study's author and an assistant professor at Harvard School of Public Health in Boston. "The bad news is that we still have a major problem with loss of insurance among millions of Medicaid and CHIP-eligible children."

Tricia Brooks, a senior fellow at Georgetown University's Center for Children and Families in Washington, DC, says the fact that 2 million uninsured children who are eligible for Medicaid or CHIP were enrolled in the prior year clearly indicates that retention should be a primary focus of these important programs.

Dr. Sommers says, "The good news is that over the past three years, the previous trend of worsening drop out has been reversed. Drop out is still a major issue, but at least we're moving in the right direction."

The retention of eligible children has improved. In a previous report, Dr. Sommers noted that one-third of uninsured children were enrolled in Medicaid or CHIP in the previous year, peaking in 2006. That drop-out rate declined to 25% in the latest study, with most of the improvement in Medicaid.

"During the same period, the rate at which uninsured eligible children enrolled has deteriorated," says Ms. Brooks. "Both of these trends suggest that enrollment and retention policies and procedures make a difference in assuring that kids get the coverage they need."

Good approaches

While retention remains a challenge, the study shows it is possible to make improvements. U.S. Department of Health and Human Services Secretary Kathleen Sebelius has set a goal to enroll the 5 million children who are uninsured, but eligible for Medicaid or CHIP.

"Streamlining the renewal application process, and making it less burdensome for parents, is the single most important approach to improving retention," according to Dr. Sommers.

Some approaches to make the renewal process easier are spacing out eligibility redeterminations to once a year instead of six months, eliminating the need for face-to-face interviews, and using a joint renewal form for Medicaid and CHIP.

Another approach is the "Express Lane" option, in which states can use information from other programs, like the free and reduced school lunch programs and food stamps, to reduce the amount of information families need to provide for Medicaid enrollment and renewal.

"Similarly, states can cross-reference names and Social Security numbers with the Social Security Administration to save families the hassle of providing citizenship documentation when applying," says Dr. Sommers.

Ms. Brooks says that most families are aware that their states have Medicaid and CHIP programs. "However, they often don't think their children are eligible or do not know how to apply for coverage," she says. "Tackling these issues through outreach and public education, along with addressing linguistic and cultural barriers, is important."

Ms. Brooks says that the ways to improve both enrollment and retention are similar. "Implementing streamlining policies, such as 12-month continuous eligibility, and aligning requirements between Medicaid and CHIP, is good place to start," she says.

Simplifying the application and renewal process is also important, with the use of technology to verify eligibility rather than requiring families to submit paperwork which eligibility workers then have to process.

Providing multiple ways to enroll or renew, including online applications, telephone renewals, and working through community partners, can help families overcome gaps in knowledge or linguistic and cultural barriers, adds Ms. Brooks.

Ms. Brooks notes that the implementation of the complex citizenship documentation requirement through the Deficit Reduction Act of 2005 had a "chilling effect" on enrollment of eligible, citizen children.

"Thankfully, CHIP reauthoriza-

tion provides a new electronic means for states to verify citizenship," says Ms. Brooks. "This is proving extremely successful in simplifying the process for eligible families and reducing the state's administrative burden and costs."

Health care reform

Many of these same approaches would likely help with enrollment and retention among newly eligible adults. "In fact, we already have research that shows that adults have even higher drop-out rates from Medicaid than children. This is a major issue," says Dr. Sommers.

Even though the Medicaid expansion mainly affects adults, Dr. Sommers says that one promising part of health reform for children is that it will bring more families together under a single plan, with both parents and children enrolled together in Medicaid.

"We know that Medicaid retention for children is significantly enhanced when their parents are also in Medicaid," says Dr. Sommers. "This offers a great opportunity to further improve the stability of children's health insurance."

Ms. Brooks says that the lessons learned from more than a decade of concerted effort to advance children's coverage provide a lot of insight into how policies, procedures, and systems should be crafted to maximize enrollment in health reform.

"States can continue to implement the best practices, and align coverage between current parent and adult coverage and children, to ramp up their ability and capacity to serve more Americans," she says. Measures to improve outreach, enrollment, retention, and coordination between programs today will help reach the 5 million uninsured — but eligible — children. "It will help their families weather the current economic storm, while improving program efficiency and cost-effectiveness in preparation for 2014," says Ms. Brooks.

Contact Ms. Brooks at (202) 365-9148 or pab62@georgetown.edu and Dr. Sommers at (617) 432-3271 or bsommers@hsph.harvard.edu. ■

Louisiana hits first-year mark with MFP program

Louisiana's Money Follows the Person (MFP) Rebalancing Demonstration focuses on three important areas for measuring results and benefits of the program. These are long-term stay in community living, quality of life measures, and fiscal measures.

"At this point, it is really too early to show any results in the state's three population groups — individuals with developmental disabilities, elders, and adults with physical disabilities," says **Julia Kenny**, assistant secretary of the Office for Citizens with Developmental Disabilities. "We are only now reaching that full-year mark with our first participant."

Louisiana's first MFP demonstration transitionee completed the 365-day demonstration period in August 2010, at which point she completed the first post-move quality of life survey. "This provided the first comparison of before and after," says Ms. Kenny. "We are eager to review the survey data, as we have observed positive outcomes that have developed in the young person's life during this past year."

The program is still analyzing the fiscal outcomes. "Generally, we know that we have been able to keep costs in line using the same "resources allocation" method we use for waiver participants," says Ms. Kenny. "This model is based on the acuity needs of individuals and is a more effective and fair way of allocating resources."

More costly than expected

In 2009, the developmental disabilities population expanded to include hospitalized children at risk for nursing home placement. "This altered some of the original program assumptions," Ms. Kenny says. "We are finding that these children's initial plans are more costly than assumed in our operational potocol, but our state's developmental disabilities service data in the Children's Choice waiver suggests we should see stabilization over time."

The state is using its current data systems to support program evaluation. Demonstration participants are flagged in the services/billing databases, so that reports can be produced specific to the demonstration.

The Medicaid office initiates a regular evaluation of Home and Community Based Services (HCBS) program utilization, including examination of participants in the demonstration as a sub-group.

"The state has requested and was awarded funding through the supplemental administrative award process to acquire contracted assistance to also develop demonstration-specific reports in the quality management data systems," adds Ms. Kenny.

The developmental disabilities population is using some new program elements that weren't previously included in the state's HCBS package. These elements are evaluated for cost-effectiveness and long-term success in community placement.

They are inclusion of children birth through 3 years of age participating in waiver services, creation of waiver opportunities for these children in the Residential Options and Children's Choice waivers, and con-

version of Intermediate Care Facility for the Developmentally Disabled beds to Residential Options.

As of July 2010, 55 people with developmental disabilities met eligibility criteria and were presented with the opportunity to participate in the MFP demonstration. Of those, 38 signed informed consent. Of that group, 22 people have moved home with family or to live independently in a community-living setting, 13 are still in the planning stage, and three revoked their informed consent for a number of reasons not related to their interest in the MFP Demonstration.

For elders and adults with physical disabilities, 182 people meeting eligibility in nursing facilities have signed informed consent. "Of that group, 45 people have moved home with family or to live independently in a community living setting, and 137 are still in the planning stage," reports Ms. Kenny.

Wait time is cut

Louisiana has never before prioritized waiver access to persons with developmental disabilities in nursing homes. Additionally, waiver services to children under 3 years of age have not been offered, leaving families to rely primarily on Early Steps services.

In addition, Louisiana has never before offered waiver services to children outside of the Request for Services Registry process, which allows families to register their child at 3 years of age.

The current wait time is eight years. "Thus, the five children who were in nursing homes or hospitals currently participating in the state's demonstration would not have an opportunity to access services otherwise, if not for the demonstration," says Ms. Kenny. "To put this into perspective, our youngest participant is just over three months old and would otherwise face a wait for services until his 11th birthday."

To date, two of the five children have moved home with their families. Due to the needs identified in this unique population segment, the state has requested significant funding in the supplemental request to support the success of these transitions.

Emotional responses

"Demonstration transition coordinators going into hospitals and nursing homes have met with hugs, tears, and thank-yous throughout the state," says Ms. Kenny.

Louisiana's MFP program is frequently finding that the longer the participant is in an institution, the harder it is to move the participant out in an expeditious manner and with a strong support structure. "For example, family members of some elders have moved out of the area and are not available for care, or the participant's former community residence is occupied or no longer available," says Ms. Kenny.

In the case of children with developmental disabilities, the families of children institutionalized for a longer term have become accustomed to a routine that does not include the intensive caretaking required.

"With other siblings involved and space concerns in the home for wheelchairs, hospital beds, and equipment, demonstration families are often required to move to accommodate the child coming home," says Ms. Kenny. "This disrupts siblings in school and the daily routine. We have had at least two families who have simply stated that these changes were too drastic and overwhelming."

One family decided not to sign informed consent, and one revoked consent after participating in months of transition planning. The state has had more success in nursing home transitions working with adult participants and families of children who have been institutionalized for a shorter period of months rather than years.

"We are excited about the reduction in length of stay to three months," says Ms. Kenny. "This will greatly assist in recruitment of participants who may have some community-based resources to return to."

Looking forward

The state anticipates meeting, and even exceeding, the originally proposed transition benchmarks for the three target populations in the existing operational protocol. However, expansion of the demonstration beyond the original benchmarks is contingent upon availability of funding for expansion of HCBS.

"HCBS expansion is required in Louisiana, since institutional bed closures are not occurring with every single transition," notes Ms. Kenny.

The state originally projected moving 20 children with developmental disabilities from nursing home placement, but this was amended to include hospitals as qualified institutions for this target group. In addition, the demonstration statute was revised, reducing the length of stay from 180 days to 90 days.

"Finally, the state Medicaid office has shown a willingness to support waiver entry for children under the age of three," says Ms. Kenny. "The original projection of 20 participants should increase over the life of the demonstration."

The state is now examining HCBS options for the behavioral health population. "CMS has counseled the state's demonstration team to consider incorporation of behavioral health transitions from nursing homes to qualified HCBS using the demonstration," says Ms. Kenny. "That is under review."

Contact Ms. Kenny at (225) 342-0095 or julia.kenny@la.gov. ■

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
State Health Watch	1 0 7 4 - 4 7 5 4	10/1/10
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$399.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Robert Mate, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Karen Young, same as above

Managing Editor *(Name and Complete Mailing Address)*
Russ Underwood, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor
	Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: State Health Watch
14. Issue Date for Circulation Data Below: September 2010

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			253	243
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	155	156
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	2	0
	(4)	Other Classes Mailed Through the USPS	20	12
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			177	168
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	5	5
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			25	25
g. Total Distribution *(Sum of 15c and 15f)*			202	193
h. Copies Not Distributed			51	50
i. Total *(Sum of 15g, and h.*			253	243
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			88%	87%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2010 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: President and CEO — Date: 9/27/10

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*