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The Newsletter on State Health Care Reform
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In This Issue

Medicaid programs under the gun to get "No Wrong Door" up and running

While some Medicaid programs have taken steps to streamline the enrollment process in recent years, the "No Wrong Door" system required by health care reform is a very different challenge. This means that a person can file a single application to find out if he or she is eligible not just for Medicaid, but also the Children's Health Insurance Program (CHIP), the "exchange" portals that will be set up so that individuals can more easily obtain health insurance and a variety of other programs.

"This is a hot topic, and is becoming even more critical as states think through the Medicaid, CHIP, and exchange linkages," says **Kip Piper**, MA, FACHE, president of the Health Results Group in Washington, DC.

States will first need to consider their current eligibility and enrollment systems to determine how much work has to be done. "The first thing on their plate is looking at their systems," says **Robin Rudowitz**, a principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured in Washington, DC. "The new requirements don't hit until 2014, but it takes a

*See **Medicaid programs** on page 2*

OK Medicaid minimizes provider cuts, hopeful for economic recovery

While some states are expecting a high-cost expansion population with complex needs in 2014, the Oklahoma Health Care Authority (OHCA), Oklahoma's Medicaid agency, expects its new enrollees may be fairly healthy. In addition, the state is seeing an uptick in revenue, which may mean that additional cuts to provider rates can be avoided.

For the group below 133% of the Federal Poverty Level (FPL), an estimated 200,000 new eligibles are expected to enroll. "We also have an estimated 50,000 children who currently qualify for SoonerCare, but are not enrolled in the program, who may be more likely to follow their parents into coverage," says **Garth L. Splinter**, MD, Oklahoma's state Medicaid director. "We currently have some eligibility groups up to 185%, mostly children, so we may be losing some of these to the Health Insurance Exchange."

Fiscal Fitness: How States Cope

About 32,000 low-income workers — up to 200% FPL — are currently enrolled in private health insurance through a premium

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Cover story

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long time to procure new eligibility systems or modify systems."

Most states don't have health information exchanges (HIEs), or anything similar, in operation currently. "So, they will need to develop those and figure out how enrollment systems are going to work," says Ms. Rudowitz. "You can't wait until 2014 to find out that the system isn't there to accommodate new applications."

Access to data is needed

According to **John G. Folkemer**, deputy secretary of health care financing at Maryland's Department of Health and Mental Hygiene, "the big challenge is coming up with a system that does everything it has to do."

"The system has to be able to accommodate a person applying by phone, in person, by fax, and over the Internet — any way at all," says Mr. Folkemer. Maryland's system needs to be much more automated, he explains, so the person applying can very quickly be sent in the right direction, whether to Medicaid, CHIP, or the HIE.

"That is really the biggest challenge that we have," says Mr. Folkemer. "We need to build a system and get it in place by 2013, so the government can approve it and we're all ready to go for 2014."

Maryland's three multiagency "No Wrong Door" workgroup subcommittees are focusing on effective education and outreach, integration of services and resources, and technology. The groups will make recommendations by the end of 2010.

Several years ago, Maryland eliminated the asset test for its CHIP program and did the same for adults after expanding coverage for parents in 2008. "We keep looking at the enrollment form and the eligibility process, trying to figure out any ways we can simplify it and make it easier," says Mr. Folkemer.

Recently, the department started working with the state controller's office to obtain data on families with children who might be eligible for Medicaid or CHIP, or parents who might be eligible for the new expanded coverage.

"We have spaces on income tax forms now, where somebody can indicate whether they have health insurance or not and whether their children do or not; they can indicate whether they are interested in getting information," says Mr. Folkemer. "We are moving more in that direction, to tie [eligibility determination] to income tax and the controller's office."

Mr. Folkemer anticipates that health reform's requirement for a common eligibility form for Medicaid, CHIP, and the HIE will be a "major, major change. We're going to have to develop a new system to be able to handle that and smoothly get the information on income tax and citizenship from the federal government."

Mr. Folkemer is hoping that the Centers for Medicare & Medicaid Services (CMS) will quickly come up with a simplified process to give states access to this data.

"In the future, we'll be relying on the IRS to provide the same kind of information that the state controller's office is now providing," says Mr. Folkemer. "At this point, I just don't know to what extent [the current process] can be incorporated into the new system."

Groundwork being laid

"No Wrong Door" eligibility systems "could be the kiosks of

tomorrow," says **Roger Gantz**, policy director for Washington Medicaid. "But what adds to the complexity is the fact that an exchange can be both a portal, and as we read it, actually do Medicaid eligibility."

The question is how the Medicaid and HIE eligibility processes can be integrated. "It is a good question. We are going to have to wrestle with that and figure out how to build on the efforts of today," says Mr. Gantz.

Washington Medicaid has been working to simplify eligibility for several years. "A work group has been in the works well before health reform passed," says Mr. Gantz. "The single portal concept is relatively new, though."

While there is a 90% federal match for Medicaid Management Information Systems (MMIS), this is not the case for eligibility systems. "Unless they are literally part of the MMIS, eligibility systems do not enjoy those match rates. We have a big ACES [Automated Client Eligibility System] system that literally does the eligibility for Medicaid and feeds our MMIS system, but we don't enjoy those match rates," says Mr. Gantz.

This means that these goals will need to be accomplished under the standard 50% match rates, at a time when the Washington Medicaid program faces major reductions. Whatever money is spent on a new information system could mean further reductions in medical coverage.

The state is trying to come up with a way to use its MAGI [Modified Adjusted Gross Income] system to simplify eligibility further. "While we have not had any formal conversations with CMS, we've been involved with the waiver process," says Mr. Gantz. "I think they would be interested in states doing some demonstration work in that area."

The current system determines eligibility for Medicaid, CHIP, and Apple Health for Kids, which covers children up to 300% of Federal Poverty Level. "Our state has been one of the few national leaders that says children are children. We have provided coverage for children whose immigration status would make them ineligible for Medicaid," says Mr. Gantz.

That record may be threatened by current budget cuts, though. The program for immigrant children, which is entirely state-funded, has been placed on the cut list for legislative consideration over the next session.

The application process can be completed online with an electronic signature, with no asset requirements. "The one thing we have not done is Express Lane Eligibility. We think it would bring on some 8,000 children that look like they would be eligible for Apple Health, but are not," says Mr. Gantz. "We have a decision package that would test that out. Unfortunately, it's coming at a time when we could conceivably reduce coverage for other programs."

Preventing eligibility loss

An annual review process helps to reduce turnover rates, but there is still disenrollment because of non-completion of applications. "That does ultimately rest with the families," says Mr. Gantz. "You would assume that the families that lost coverage would come back eventually, but over half of them do not."

The idea of "passive eligibility" was considered, where a family would remain eligible unless the department heard otherwise. "That is one of the questions that we wrestle with. But based on the analysis we did, we can't do that," says Mr. Gantz. "More than half don't come back on, and we're paying a premium to a health plan. That's not prudent either."

Instead, calls are made to remind families of upcoming renewal dates and to offer help if needed. This outreach work, done by community-based organizations, is expected to help lay the groundwork for health care reform. "We can build on the work that they have done with low-income populations. That will extend into the exchange," says Mr. Gantz.

A system is needed to ensure that someone doesn't lose eligibility just because he or she fails to complete an application. "But having said that, my assumption is that there will be at least an annual renewal process for coverage in the exchange. What happens if somebody doesn't complete the renewal process?" asks Mr. Gantz.

The assumption may be made that these individuals are now low-income and need to be on Medicaid. "If so, then Medicaid will need information, because we don't know where they are," says Mr. Gantz.

Mr. Gantz adds that he believes the mechanisms already in place to sustain eligibility for low-income families will prove useful for outreach for the Medicaid expansion population in 2014.

"We will bring on 400,000 new people in the Medicaid program eventually, so we've got more people to look at," says Mr. Gantz. "Childless adults will bring on a new set of challenges, but at least we have an infrastructure to build from."

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Fiscal Fitness

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assistance program called Insure Oklahoma. Small business owners and their employees can participate in the program, which subsidizes the qualified employee's premiums in private market health insurance. "That group will, for the most part, end up going through the exchange. Most will continue in private insurance, and some will end up in Medicaid," says Dr. Splinter.

Fiscal impact of reform

To prepare for health reform, Dr. Splinter says, "We are trying to get the whole medical delivery system in Oklahoma seamlessly integrated with electronic sharing of information."

The overall impact on the state's budget is not yet known. Despite the cost of the Medicaid expansion being borne by the federal government for a number of years, this is still a concern.

"Every state is being stressed by budget issues, especially for the coming 2012 fiscal year, so anything that adds to the cost will be a big issue," says Dr. Splinter. "The feds are on one hand saying, 'Get ready to do this big expansion,' and on the other hand saying, 'You'll have to bear some of the costs.' This is at the same time our budgets are being cut."

The state's Federally Qualified Health Centers (FQHCs) may have to change their business model. This is because these centers see a large number of uninsured patients. "They are partly in business to see the indigent care load. If everyone has access to insurance, that's not as large an issue," says Dr. Splinter. "However, access of those pieces of the delivery system will still be needed. The FQHCs will begin to look more like private clinics."

The state's Disproportionate Share Hospitals currently offer a variety of programs to take care of indigent patients, such as free clinics. "They will potentially change the nature of their operations, if everyone has insurance," says Dr. Splinter.

Staffing changes at the state level will be necessary under reform. "If our agency becomes the designated agency for the exchange, or even if it's a different agency, there will be people that get shifted into new jobs," says Dr. Splinter. "We'll have some areas that don't need as much staffing, and we'll have new functions that need to be done."

This type of reorganization occurred previously at OHCA when the SoonerCare (Oklahoma Medicaid) program was transferred to the agency and converted to managed care in 1995. "That will be one of the challenges in balancing the resources to meet the new federal requirements," says Dr. Splinter.

Recovery in sight?

Major cuts to SoonerCare were avoided throughout the recession, in part because of support from the legislature. "At a time when state budgets were decreased overall by 7% or 8%, we were essentially held flat," says Dr. Splinter. "So, in a conservative state with a Democratic governor and a Republican House and Senate, the SoonerCare program came out fairly well in a down budget. That was actually, in many ways, a vote of support by the Republican leadership in the House and Senate for the work of this agency."

As a last option, the provider fee schedule was cut, but no services were cut. A 3.25% across-the-board provider rate cut was made, which was estimated to account for $84 million in total dollars. "We had finally achieved 100% of Medicare rates, and now we are at 96.75%. We hated to have to back off that," says Dr. Splinter. "We thought we would have to do an equal amount again."

For the past few months, enrollment increases have leveled off, and there have been some increases in state revenues. "State revenue has gone up 6.8% YTD from last year and 4% higher than was forecast. So, the state fiscal outlook is looking a little bit better than was anticipated," says Dr. Splinter.

Due to the uptick in revenue, the provider fee schedule cut was dropped for FY 2011. "So far, we are not spending as much time on contingency plans for things getting worse," adds Dr. Splinter.

Contact Dr. Splinter at (405) 522-7365 or garth.splinter@okhca.org. ■

Newly revamped Medicaid enrollment systems aim to meet 2014 requirements

The Oklahoma Health Care Authority has just gone live with a new enrollment system, which has laid the groundwork for the Health Insurance Exchanges (HIEs) that need to be in place by 2014.

"Right now, we are thinking that it will fit very well with the whole exchange process," says **Garth L. Splinter**, MD, Oklahoma's state Medicaid director. "It is very similar to the exchange needs, in terms of an electronic enrollment system and a way to sort people into the right category." The goal is to have a debugged, well-functioning system well before 2014.

Most of the Insure Oklahoma program's enrollees have private health insurance coverage. "So, we

already have a process that looks very much like the exchange function," says Dr. Splinter. "Plans are qualified, and a website makes all that information available, so people can enroll online. They can be enrolled into private plans, with an attached subsidy. That is very much what the exchange envisions." With Insure Oklahoma, money is sent to the employer as a subsidy.

"We think that for some of the mechanisms, we have some of those things in place," says Dr. Splinter. "We already have the mindset necessary to go down that path to do similar things."

Timing is right

Speed and accuracy are expected to increase in the current online enrollment process. "Members are able to access it in multiple locations, and we don't have any worry about miscoding or handwriting," says Dr. Splinter. Information is verified in real time, and applicants are referred to other programs they might be eligible for, such as the Special Supplemental Nutrition Program for Women, Infants and Children.

This system of eligibility allows for more efficient use of state dollars. For instance, when the system processes the Department of Mental Health's claims for outside provider services, it also checks to see if individuals qualify for SoonerCare in order to use federal matching dollars.

"Previously, we had been paying 100% of state dollars for services for what would have been available for federal match," explains Dr. Splinter. "Now, we can get these people enrolled in Medicaid as we identify them."

Both of the recent implementations were being planned before health care reform, but the timing was clearly fortuitous. "There is plenty of time to debug it and educate users," Dr. Splinter says. "I fully expect that we will have some interest from other states about how we are doing the electronic enrollment."

Single point of entry

Connecticut now has a single point-of-entry service, which **Michael P. Starkowski**, commissioner of Connecticut's Department of Social Services, calls an "Exchange Light." This provides an array of opportunities for children and adults who need insurance, he says.

Clients are automatically screened for the Husky A program (which covers children, parents and relative caregivers up to 185% of the FPL, and pregnant women up to 250%), Husky B (Connecticut's CHIP program, which covers children over 185% of the FPL regardless of income, with those who hit 300% FPL paying the full premium that was negotiated with the managed care organizations), the Charter Oak program, traditional Medicaid, the new Medicaid for Low-Income Adults program and the pre-existing condition insurance plan (temporary high-risk pool).

"All of these are coming through that one single point-of-entry servicer. You have individuals being screened for the most affordable and appropriate product for them, based on their circumstances," says Mr. Starkowski. The system allows clients to select the most cost-effective product for them, based on their medical condition and what they can afford.

If an applicant isn't eligible for Husky A, for example, he or she is automatically screened for the Medicaid for Low-Income Adults program. If they aren't eligible for that program, they are screened for Charter Oak.

However, the applicant might choose not to enroll in the Charter Oak program because of its annual limitation on medical services of $100,000 and $7,500 for pharmaceuticals. "Someone might choose to join the high-risk pool if they have a severe pre-existing condition, and they know their medical costs will be significant during the year," explains Mr. Starkowski.

Massachusetts just replaced its core claims system, which went live in May 1999. "It is just a dream to work with," says **Phil Poley**, chief operating officer for MassHealth. "The reason we did this is to be able to make changes fairly rapidly, with a flexible, usable system," he says. "Making eligibility system changes is harder, because our eligibility system was built to older standards."

The eligibility system is a legacy system. "It is fine and it performs the way we need it to, but there are things about it that limit us, particularly in the design of notices to members," says Mr. Poley. "The physical hardware and software is older. Also, when you build a new MMIS, you build multiple environments that you can test before you get to a production environment."

Since older systems were not built with that multiple environment approach, it's necessary to bundle all software releases at once, because they can only get tested at one time.

"If CMS were smart, they would make 90% match money for states to redesign eligibility systems and also find a way to encourage states to collaborate on that," says Mr. Poley. "There's no reason why multiple states couldn't share a technology platform."

Contact Mr. Starkowski at (860) 424-5054 or Michael.starkowski@ct.gov. ■

Alaska's small, isolated population centers pose unique enrollment challenges

Alaska Medicaid now has a simplified application process, with a relatively short application and no interview requirement. However, according to **William Streur**, deputy commissioner of the Alaska Department of Health and Social Services (DHSS), the impact of these recent changes is not yet clear.

"Alaska is a unique state with mostly small and isolated population centers with limited technology options," notes Mr. Streur. "The value and effect of these and other efforts to affect enrollment will remain unknowns for some time to come."

Applications are widely available in the community at public assistance field offices, medical providers, Native regional organizations, and community-based organizations. Alaska's smallest and most remote communities access the program through a network of more than 300 fee agents serving close to 200 rural communities. A printer-friendly version of the application is also available online.

"The state of Alaska works closely with large regional health organizations, largely operated by Native nonprofits, to help ensure access and enrollment of eligible individuals," says Mr. Streur. These organizations are allowed limited, read-only access to the department's Division of Public Assistance (DPA) eligibility information system. This is done to ascertain the status of patients in order to confirm eligibility or to facilitate program access.

DPA also has outstationed eligibility staff at one large, urban Native health facility to help expedite processing of applications. "Whenever possible, DPA staff participate in outreach activities to help raise community awareness and understanding about Medicaid and other public assistance programs," says Mr. Streur. Recently, staff had a booth at the Alaska Federation of Natives conference and were featured in a talk show about Denali KidCare on public radio.

The department is using "Lean" business practices to improve core processes that drive program access and service quality across the organization. "We anticipate that these efforts will result in further improvements in business processes that support enrollment efforts," says Mr. Streur.

Technology is issue

The department is still exploring the range of opportunities offered by initiatives such as Express Lane Eligibility and the operational impacts of health care reform. Meanwhile, the efforts to streamline basic business practices and processes already have had a positive impact.

"For 2009, DHSS received almost $800,000 in Medicaid bonus funds for its successful efforts to increase enrollment and participation in Medicaid programs," says Mr. Streur. "These gains have been made while maintaining high levels of accuracy as measured by [Payment Error Rate Measurement] PERM reviews."

Any enrollment system that relies heavily on technology is going to be problematic in Alaska. "The state's enormous size makes direct service delivery a challenge. It is no different with distance delivery," says Mr. Streur. "The state's digital infrastructure is still developing. Especially in rural communities, it often does not adequately support technologies that rely on high-speed Internet transmissions."

Without a better infrastructure, technologies such as service kiosks and online applications would be ineffective and difficult to sustain.

"DHSS did support a grant application by the State of Alaska Library System to provide high-speed Internet access in public libraries in rural Alaska," says Mr. Streur. "It is hoped that this might serve as a portal for better access for people in a limited number of smaller communities."

Contact Mr. Streur at william.streur@alaska.gov or (907) 334-2520. ■

Health reform puts spotlight on enrollment, retention of adults in Medicaid

Many state Medicaid programs have made impressive headway in streamlining enrollment for children. Now, health care reform is causing them to turn their attention to the adult population.

"Research shows that Medicaid enrollment and retention among eligible adults is significantly worse than among eligible children. There is a real gap that needs to be addressed," says **Benjamin D. Sommers**, MD, PhD, an assistant professor at Harvard School of Public Health in Boston.

One reason is that there has simply been more focus on these issues for children, with more research and grant funding for outreach. "There are also procedural reasons," says Dr. Sommers. "Some states have contin-

ued to use more restrictive or burdensome enrollment requirements for parents applying for Medicaid, compared to children."

States are more likely to use asset tests for adults. "This can be an obstacle to coverage even among eligible individuals, since these tests require more documentation," says Dr. Sommers. "But many states have tried to align these enrollment procedures for children and adults, which is a good step."

Lessons learned

Nearly 5 million uninsured children who are eligible for public coverage are currently uninsured. "We're doing better for children and can apply some of those lessons to adults. The challenge is that while states are doing better for children, there is still a lot of work to be done there too," says Dr. Sommers. "We're in need of improvements in enrollment and retention for everyone eligible for Medicaid, regardless of age."

Rhonda Seltz is coordinator of Radford University's FAMIS (Family Access to Medical Insurance Security) Outreach Project, which has increased the number of eligible children enrolled in Virginia's program. Here are some of the approaches used for outreach:

• Strong partnerships with schools are utilized.

Back-to-school campaigns distribute flyers advertising state-sponsored health coverage with contact numbers for local departments of social services and the central processing unit. Phone numbers for local outreach projects are also provided.

Families identify whether they have health coverage for their children on the required school health information cards. This allows the school nurse to refer the family to an outreach project that will make every effort to get the children enrolled in coverage.

"These workers go the extra mile to help the family complete the application," says Ms. Seltz. "That may mean a home visit in the evening or meeting the family at their place of employment during a lunch break."

• Outreach workers send reminders of upcoming renewal dates.

They also offer face-to-face assistance with completing renewal forms and assist with retrieval of income verification and citizenship documents if needed.

Retaining coverage of children is a challenge, in part, because families move without providing new addresses. "There are changes in eligibility rules from year to year that confuse families," says Ms. Seltz. "Families may just not understand that they need to renew, or may not be able to provide adequate income documentation in time."

• Media outlets are utilized.

"This not only increases awareness, but also adds credibility to the program," says Ms. Seltz. "Recent budget cuts have created less visibility via television and radio ads, which previously were able to reach numerous families."

• Partnerships with local workforce centers and unemployment offices are used.

"These have been very effective in many areas across the state in getting children and pregnant women signed up for state-sponsored health insurance programs," says Ms. Seltz.

Outreach workers onsite at a local workforce center in Southwest Virginia found that many people had never heard of the FAMIS program.

"Most families assume that their children are not eligible for Medicaid, because the family may have some income and assets," says Ms. Seltz. "It is upsetting to know that many of these kids could have been covered by Medicaid all along, as assets are not counted for Medicaid eligibility."

Big contrast in process

Ms. Seltz says that these successful outreach strategies will be helpful for the adult population coming onto the program in 2014. "In Virginia, at least, adult and children's Medicaid are two totally different 'animals,'" she says. "Virginia ranks near the very bottom when looking at income eligibility guidelines for adult Medicaid. In 2014, when adults with income under 133% of the poverty line can qualify for Medicaid, the need for education, coordination, and advocacy will be even greater."

Today, in order to qualify for adult Medicaid in Virginia, the individual must be a parent, disabled, pregnant, or over age 65. Disabled and elderly people must meet asset requirements, and parents "have to be almost destitute to qualify," says Ms. Seltz. The application process in Virginia is quite extensive, requiring the completion of a 14-page application, and documentation for applicable income and asset rules, and citizenship.

In contrast, Virginia has made great strides over the years in simplifying the application process for children's health insurance. There is a much smaller four-page application, no mandatory cooperation with child support enforcement requirement, and no face-to-face interview required. Parents can apply for their children by mail with their local DSS, online, by phone, by mail with the central processing unit, or with their local outreach project.

This "No Wrong Door" policy allows families to have their children assessed for both children's Medicaid and FAMIS at the same time. The eligibility worker can often verify citizenship and

incomes, such as unemployment, Social Security, or child support without asking for hard-copy verifications.

There are several reasons for the discrepancy in the current application processes between adults and children. "There is the issue of limited funding and the belief held by many voters that children, unlike adults, are not 'responsible' for their situation. They think adults should be able to pick themselves up by their boot straps, work, get insurance, and pay their own bills without the taxpayers' help," says Ms. Seltz. "Unfortunately, though, individuals' lives do not fit neatly in a nice black and white box."

Ms. Seltz says that a long history of streamlining enrollment for children's health insurance is particularly useful at this juncture. "States can take the very valuable lessons learned over the last 12 or 13 years to coordinate, simplify, and expedite the influx of new adult Medicaid applicants when health reform is fully implemented in 2014," says Ms. Seltz.

One possible complication, though, is that there are insufficient numbers of Medicaid providers. "In rural communities, there are often shortages of providers. The Medicaid reimbursement rate is quite low in Virginia, as well," says Ms. Seltz. "You can have all the insurance in the world, but if you cannot locate a provider, the coverage is worthless — even if it is 'free.'"

Contact Ms. Seltz at (540) 831-7693 or rgseltz@radford.edu and Dr. Sommers at (617) 432-3271 or bsommers@hsph.harvard.edu. ■

GAO report: Medicaid rate setting may not be "actuarially sound"

The Centers for Medicare & Medicaid Services (CMS) is failing to ensure that rates paid to managed care organizations serving Medicaid clients aren't too high or too low, according to an August 2010 report from the U.S. Government Accountability Office (GAO).

Managed care organizations are serving an increasing number of Medicaid beneficiaries and are paid on a predetermined, per-person basis, with the rates set by the states. Federal law requires that the rates are "actuarially sound." This means that the rates are not too high or too low and reflect the costs, populations served, and services covered by the contract with the state.

Rates that are too low can mean problems with access. This is occurring in some states, especially in light of provider rate cuts made recently, according to the report, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*.

The report's findings weren't surprising, says **Margaret A. Murray**, chief executive officer of the Association for Community Affiliated Plans (ACAP) in Washington, DC, which represents nonprofit Medicaid managed care health plans.

"We have been concerned about this for quite some time," she says. "We had encouraged the Senate Finance Committee to look at this issue, and that's partly why they put it into the [Children's Health Insurance Program Reauthorization Act of 2009]."

ACAP wants CMS to more clearly define how it measures "actuarial soundness" and require states to be more transparent in how they determine rates. "States will say, 'Here are the rates, take them or leave them,'" says Ms. Murray. "We would like to know what trending factors were used. What is the justification for them?"

Ms. Murray suggests that an administrative channel should be established for health plans to raise concerns with CMS about the actuarial soundness of rates set by a state.

ACAP also would like to see CMS send a letter informing state Medicaid directors that states must share trend assumptions and baseline data with health plans. They also want to see some type of administrative remedy in place, so health plans could go to the central office at CMS — if they don't agree with the rates — and adjudicate whether the rates are adequate.

"Right now it's a 'Take it or leave it' situation. Many of the for-profit plans say, 'Leave it,'" says Ms. Murray. "Some of the plans were told they would get a 0% rate increase for pharmacy without any justification for how the actuaries came up with that."

She adds that it is especially important for plans to have the resources they need to provide care to an estimated 18 million individuals expected to come onto the Medicaid program in 2014. "Based on experiences with the CHIP program, about 70% ended up in managed care. This is a similar population and benefit package," notes Ms. Murray.

If a plan is only in one state with one customer, they may be forced to accept rates that are too low. "They can do this for a year or two if they have the reserves," says Ms. Murray. "But by giving them no choice, the states are undermining the Medicaid managed care plans."

Contact Ms. Murray at (202) 204-7509 or MMurray@communityplans.net. ■

Texas makes "huge strides" in improving Medicaid long-term care services

Marc S. Gold, director of the Promoting Independence Initiative in the Texas Department of Aging and Disability Services, says that the state has made "huge strides in attendant services" since the 1980s.

At that time, Texas was the only state to take advantage of a demonstration waiver program called the Frail Elderly program, which allowed states to provide attendant services up to 300% of the Federal Poverty Level. Texas has had this program, now called the Community Attendant Services program, in place ever since.

"Overall, including individuals [in] both the disabilities and older population, we are serving approximately 71% of the population in a community-based service program," says Mr. Gold.

Services given with no wait

Mr. Gold notes that in addition to looking at overall dollar expenditures, it's important to look at the actual number of individuals being served. Part of the problem, he explains, is that some statistics on long-term care programs don't include managed care data.

In 2008, Texas expanded managed care for its older and physically disabled population to most of the urban areas in the state. "Those numbers aren't being included, and that is a big problem," says Mr. Gold. "When you do include those, it's pretty significant in showing the direction that the state of Texas has gone."

He explains that one advantage of managed care is that individuals on Supplemental Security Income (SSI) are given services immediately. This is because in the managed care areas, individuals get waiver-type services as an entitlement instead of going on interest lists. "That is a big deal, because Texas, like many states, has long interest lists. We don't call them waiting lists, because individuals haven't been predetermined to be eligible," says Mr. Gold.

"The other big area where the state of Texas has really succeeded and excelled is our Promoting Independence Initiative," says Mr. Gold.

One major focus of that program is the relocation of individuals from intermediate care facilities for persons with mental retardation (ICF/MRs) with nine or more beds, and from nursing facilities.

What they get is an expedited access to their waiver program, which normally has a multiple year wait time," says Mr. Gold. Since 2001, more than 3,000 people have been relocated from private facilities and the publicly funded ICF/MRs.

The state of Texas has been actively relocating individuals from nursing facilities for nine years. "A large part of the MFP demonstration that was included in the Deficit Reduction Act was based on the activities in the state of Texas," says Mr. Gold. "We have moved out over 21,000 individuals since 2001."

For the MFP demonstration, all of the original benchmarks were met in 2010. "So, we are going to ask for an extension for those," says Mr. Gold.

Under the MFP demonstration, incentive money is provided for privately owned ICF/MRs with nine or more beds to voluntarily close their facility, change their business plan, and offer waiver spots to individuals.

Five facilities have been closed to date, with five more pending. This comprises 700 to 800 beds. "We are providing incentives to close the facilities and offering people choices. We are taking the money and putting it back into the community," says Mr. Gold. "That is something we have been very successful with."

All ages, complexities

Individuals with co-occurring behavioral health and physical health needs who are currently residents of nursing facilities are able to receive additional services than they would normally receive under the waiver program.

"That program, too, has been very successful in moving people who may have been caught in that cycle," says Mr. Gold. "We have about 88% remaining in the community for that population."

The program was originally implemented in San Antonio and is now being expanded to all of the contiguous counties and the Austin area.

Impressive results over the long term have for the most part dispelled the initial concerns voiced when the program was first being talked about in the 1980s. "There were obviously a lot of concerns by all the stakeholders — the provider base, advocates, families, and guardians — about how to serve a nursing home population successfully in the community," says Mr. Gold.

The biggest worries involved individuals with more complex needs. To alleviate these concerns, relocation specialists were hired to act as facilitators.

"They also work as housing navigators for individuals who have lost their community supports," says Mr. Gold. "One of the biggest barriers for individuals who have been institutionalized for a period of time is housing."

In addition to working with nursing facilities, the program is also working with home health agencies. The goal is for them to take on more individuals with complex needs, such as patients on ventilators.

Initially, Mr. Gold himself assumed that it would be the younger disabled individuals who would take advantage of the opportunity. "But our data demonstrated we were serving a large population over 60," he says. "We have 16 people right now over 100, who are living successfully in the community, as a result of MFP." About 25% of the population receiving Home and Community Based Services are over 80.

The program has also had good results with showing that developmentally disabled individuals who have been in the larger ICF/MRs, both private and state-supported, can be served successfully in the community.

"This impacts individuals of all ages and complexity levels," says Mr. Gold. "With history, experience, and word of mouth, it's really removing those doubts. People want to at least give it a try."

Texas' MFP data has not shown higher levels of remission, increased levels of abuse or neglect, or acute episodes occurring for individuals after they've relocated. Mr. Gold notes that when looking at overall costs, one has to consider not only the long-term services cost, but also acute care costs and residential costs.

"If you were to look at our legislative appropriations request, it will demonstrate that on average, the cost is cheaper to serve an individual in a community-based setting," says Mr. Gold.

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Barriers for mental health in medical homes are key concern for Medicaid

Mental health services are not typically included in patient-centered medical homes, and lack of reimbursement is one reason. In most states and in most private insurance plans, mental health specialists cannot be reimbursed for care provided in primary care settings. In addition, if a primary care provider sees a patient solely for a mental health condition, there is no reimbursement for that care.

"That's just the way the rules are. It's the result of creation of mental health carve-outs that are designed to manage mental health care in specialty settings," says **Thomas Croghan**, MD, a senior fellow at Mathematica Policy Research and adjunct professor of medicine and psychiatry at Georgetown University School of Medicine, both in Washington, DC.

This ensures that care is not reimbursed outside the specialty sector. "They provide specialty care and have done very well at that, but they've also created artificial barriers as a way of controlling costs," says Dr. Croghan. "There is a whole set of insurance and reimbursement barriers to delivering care that need to be addressed."

The collaborative care model of delivering mental health care involves a set of standardized protocols for identifying and treating conditions. In many Medicaid programs, there are barriers to this sort of team-based care.

"These teams commonly include a primary care provider, a mental health specialist of some sort, and a care manager," says Dr. Croghan. "Most insurance plans are not set up right now to be able to reimburse providers for the things they do when providing team-based care."

Integrating Mental Health Treatment Into the Patient Centered Medical Home, a June 2010 white paper completed by Mathematica Policy Research for the Agency for Healthcare Research and Quality, compared current strategies used to deliver mental health treatment in primary care with those used in medical homes.

"There are a lot of good ideas to develop care plans for problems like depression and diabetes," says **Wayne Katon**, MD, professor, vice-chair and director of the Division of Health Services and Psychiatric Epidemiology at University of Washington Medical School in Seattle. "But most of the guidelines for developing practices for medical homes have not mentioned mental health as an integral part for developing health care, and I think that's a problem."

Viability of primary care

There are many more people with mental illness than can possibly be adequately treated in the specialty sector. In fact, though, this is often not necessary, according to Dr. Croghan.

"Many people have mental disorders that can be perfectly well treated by primary care physicians," says Dr. Croghan. "In fact, primary care providers are in a better position to diagnose them, because they come to the office with other medical illnesses. It would make sense to move in that direction."

However, primary care doctors may feel unprepared to care for common mental health problems. "The primary care offices tend to be very chaotic in terms of workload, with very short visits. If somebody has two or three health problems and one mental health disorder, very often providers prioritize the physi-

cal health problems. The mental health problems don't get addressed, because they take more time," says Dr. Croghan.

Historically, there has been a problem with the quality of care provided to people with mental health disorders by primary care physicians, notes Dr. Katon. There is also less rigorous training in medical school and residencies in treating mental health conditions.

In addition, those with severe mental health disorders often don't get good primary care for chronic medical problems. "There is a need to make sure that primary care doctors are available to patients in their usual treatment setting," says Dr. Croghan. "This is an area where we need to do some really constructive thinking for how to best provide this care for a very vulnerable group of patients."

Dr. Katon says that the medical home concept is, to some extent, a political and economic movement to make primary care more viable. "Primary care has been so difficult in the last 10 or 20 years, as payments for visits have decreased," he says. "Doctors were forced to see more and more patients each day. There has been a lack of continuity of good services for patients."

At the same time, there is a growing focus on improving the quality of care for people with chronic illnesses. "Obviously, you can't have more patients every day and better quality. Those two concepts are at loggerheads with each other," says Dr. Katon. Fewer medical students are going into primary care, due to the pressures of seeing more patients with less autonomy.

"Medical homes are a well-meaning concept that may indeed make primary care more viable, but the proof that it actually improves care is still very limited," says Dr. Katon. "My own view of it is that the medical health movement could help integrate evidence-proven models like collaborative care for depression into medical home. The question of how will it be paid for is a problem."

If one of the goals of the medical home movement is to provide more funding to make primary care more viable, and mental health is integrated into primary care, there is a question of how this would be reimbursed. "Where would that money come from? Would it come from medical home payments or some other way of providing care?" asks Dr. Katon.

Successful models

Some evidence-based models have been shown to significantly increase the quality and outcomes for common mental health disorders in primary care. One is collaborative care, in which an allied health professional provides extra visits to educate a patient about his or her condition, and tracks adherence and symptoms. If the patient is not doing well, return visits are arranged with the doctor or a mental health professional.

"There are 37 trials for collaborative care depression that have shown it to be a very effective model, but almost nothing in the medical home concept has mentioned anything about that as a way to integrate mental health care," says Dr. Katon. "Almost none of the state criteria or insurance criteria for medical homes say anything about integrating models like collaborative care into medical homes."

There is not clear evidence as to whether having a medical home alone will result in better care for any chronic conditions, whether physical or mental health disorders.

"There are some studies that suggest the medical home concept could improve those things, but we don't have that conclusive data," says Dr. Katon. "It's certainly not there in randomized trials."

Dr. Katon says that he doesn't believe that the medical home concept alone is enough to truly improve outcomes for diabetes or depression. He says that disease management models such as collaborative care must be integrated into primary care. "I think that could happen, but it isn't being spoken of overtly right now with the medical home concept. If I was a Medicaid director, I would be quite concerned about this," says Dr. Katon.

This is because the rates of mental illness in Medicaid patients are two- or threefold what they are in the general population. "And medical homes are not talking about mental health, or to provide clearer standards for what you would have to do to provide better outcomes," says Dr. Katon.

"There are other movements afoot like the parity movement, where people are supposed to get equal reimbursement. But health reform has been strangely silent about mental health being an integral part of medical care."

Financial incentives

Dr. Katon says that in order to improve quality of care, whether for mental health or other chronic illnesses, financial incentives for primary care physicians must be tied to outcomes.

"Right now, there is a pay-for-performance movement in our country where insurers are paying for performance criteria for chronic illnesses. But there is not much proof that [this movement] has led to enhanced outcomes," says Dr. Katon. "Financial incentives need to be for enhanced outcomes and not just performance."

Dr. Katon explains that he believes the medical home concept is an effective approach to keep primary care more viable, including incentives to improve continuity of care for people with complex illness.

"We have to provide them with enough financial incentives so that [they] have the time to do this," says Dr. Katon. "You can't argue with that, but it will need to go a step further to improve quality of care for patients with chronic illnesses, particularly mental illnesses. And I think the talk about it and integration of it is still lagging behind."

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Bazelon Center lauds GA/U.S. Justice agreement

The Bazelon Center for Mental Health Law voiced its support for the U.S. Department of Justice and the State of Georgia for reaching agreement in a lawsuit aimed at moving people in Georgia who have mental disabilities out of "harmful state institutions and serving them instead in the community."

"While not a panacea, this agreement takes the first step to ensuring that Georgians are afforded mental health services that are fully integrated into the community, as the *Olmstead* Supreme Court decision and the Americans with Disabilities Act demand," said Robert Bernstein, PhD, executive director of the Bazelon Center, based in Washington, DC, in a news release from the center.

The center represents a coalition of stakeholders that has advised the federal district court in the case, known as *United States v. Georgia*. ■