State Health Watch

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In This Issue

Reform may be a good deal, not a fiscal disaster, for Medicaid programs

Is it a foregone conclusion that for many states, the expansion of Medicaid in 2014 will be next to impossible, fiscally speaking? In fact, some analysts, and also some state Medicaid directors, say that Medicaid programs should come out ahead.

"In some cases, concerns expressed by states about the Medicaid expansion's impact on their budgets has been overblown," says **John Holahan**, PhD, health policy center director at the Urban Institute in Washington, DC.

Costs actually will be quite modest, according to *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Poverty*, a May 2010 study by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, also in Washington, DC.

"There are a lot of ways in which states will save, probably about as much money as they have to put up," says Dr. Holahan. "States that have complained vigorously about this are typically both overstating their Medicaid costs and not counting the offsetting costs."

Dr. Holahan says that he sees health care reform as "very good fiscal news for states. In some states,

See ***Medicaid reform*** *on page 2*

More managed care in Washington sets stage for Medicaid expansion

A greater percentage of Washington state's Medicaid population is being moved into managed care, most likely beginning with the Supplemental Security Income (SSI) population. "We will be going out with an RFP next year, for a start date of early 2012," reports **MaryAnne Lindeblad**, assistant secretary of the state's Department of Social and Health Services.

Currently, about 60% of the state's Medicaid population is in managed care. This will be expanded to more than 85%. "We will look at ways to support innovation within our contracts," explains Ms. Lindeblad. "The capacity of health plans will be looked at, and also innovative payment plans that they will use for providers, to support the concept of health homes. We are going to come at it from that direction, too."

A joint procurement exercise is currently under way for the state's Basic Health program, a state-sponsored program providing low-cost health care coverage through private health plans. "We are doing this in

Fiscal Fitness: How States Cope

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

State Health Watch
The Newsletter on State Health Care Reform

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Cover story

Continued from page 1

they have overstated the Medicaid costs of the Medicaid part of it. They either assume the cost per person is too high or assume higher takeup rates than we have evidence for." Other key findings:

- While the average state's Medicaid enrollment will increase by 27.4%, state costs will increase by just 1.4% on average. This is mainly because the federal government will bear more than 95% of the total Medicaid expansion cost, as compared to roughly 57% of current Medicaid costs.
- Expansion of coverage will likely reduce state costs associated with providing uncompensated care to the uninsured.
- Only between 57% and 75% of those who become eligible for Medicaid will enroll. A much lower percentage of people with private coverage will exchange it for Medicaid coverage.

"If anything was surprising, it was how big the federal share was," says Dr. Holahan, the study's lead author. "When you really compute the numbers and see them in front of you, there are a lot of federal dollars coming to states. While I recognize that it may be hard for some states to come up with their share of the money, the amount they have to spend is pretty small."

States will see savings

States and localities may support clinics and public hospitals with direct appropriations or various kinds of subsidies, and programs for mental illness or substance abuse may be funded directly through state funds. These programs, run by state governments, may no longer be necessary when millions of additional people have Medicaid coverage.

"A lot of that will be covered as a Medicaid benefit," says Dr. Holahan. "There are a lot of ways in which states will save money, though this will vary among states."

States often express concern over the "woodwork" population coming onto the program in large numbers, consisting of individuals who are already eligible for Medicaid but not enrolled. This group would be more of a financial burden for states than newly eligible individuals because of lower federal match rates.

"I think the jury is out on how much of a problem that will be, but to the extent these individuals are uninsured today, states and localities are paying a lot of their care as it is," notes Dr. Holahan.

$800 million in savings

John G. Folkemer, deputy secretary of health care financing at Maryland's Department of Health and Mental Hygiene, says that "overall, fiscally, we think that health reform saves the state money. Over the next ten years, we will probably save over $800 million as we start to phase it in, for a lot of different reasons."

While Maryland Medicaid hasn't cut any optional services, some significant provider rate cuts have been made. In addition, some provider taxes got increased, he says.

"Maryland, like other states, has faced tight coffers over the last few years. Enrollment is still going up, with more than 200,000 additional people coming onto the program over the last two or three years," reports Mr. Folkemer. "The rate of growth isn't what it was a year or two ago, but it is still growing every single month."

Not many parents are expected to come on to the program as part of the expansion population, because the state's Medicaid program already covers up to 116% FPL for parents. "Using the current rules, there are a lot of disregards.

Once you take that into account, and the different way eligibility will be calculated under health care reform, our growth is going to be with the childless adults that don't have any dependent children at home," says Mr. Folkemer.

The pharmacy rebate for individuals in managed care organizations brings significant savings to Maryland, he says.

"Starting in 2014, the state will receive 100% federal funding for its Primary Adult Care program, for which it receives 50% federal funding to provide limited benefits for childless adults, as well as for newly eligible parents for a three-year period," says Mr. Folkemer.

Maryland has the third largest high-risk insurance program in the country. "That presumably would go away when all of those people qualify for regular health insurance," says Mr. Folkemer. "Also, we have a 2% tax on all insurers in the state. As more people have insurance, there is going to be more revenue coming in. So, there are a whole series of things that will produce savings. That will more than offset the costs."

Since health care reform includes opportunities for quality initiatives, this could lead to cost savings over the long term, Mr. Folkemer says that Maryland Medicaid already has many quality initiatives in place, particularly for the managed care organizations, which cover 80% of Medicaid enrollees.

These include quality reviews, Healthcare Effectiveness Data and Information Set (HEDIS) reviews, value-based purchasing, and provider surveys. A pay-for-performance component was recently implemented for nursing homes, with extra payments for meeting certain criteria.

"On the hospital side, because we have the all-payer waiver under the Health Services Cost Review Commission, there are some initiatives under way looking at such things as hospital-acquired conditions, readmission, and infection rates," says Mr. Folkemer. "For hospital services, we are working on things that involve all payers — not just Medicaid. There might be a few more opportunities that come up after health care reform, though."

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Fiscal Fitness

Continued from page 1

conjunction with our Basic Health plan, to look at creating that continuum of health plans for low-income populations," says Ms. Lindeblad.

The managed care expansion is also setting the stage for the upcoming Medicaid expansion. "Our vision is to develop the RFP in such a way that it helps us to identify the partners that we want to do business with for 2014," explains Ms. Lindeblad. "Payment reform is an underpinning of that. We really want to help our health plans look at ways of being innovative."

The managed care expansion is being looked at as a vehicle for better care coordination. "We've had success with our Healthy Options population. We want to expand that into other populations," Ms. Lindeblad says. "It's a way to implement the health home medical concept, as opposed to a fee-for-service approach."

The department is looking for health plans that can offer some innovative approaches. This might mean building accountable care organizations or other kinds of accountable delivery systems. "We are looking at how we can hold the health care system more accountable for the services that we buy," explains Ms. Lindeblad.

Current fiscal challenges

Meanwhile, the sustainability of the existing Medicaid program is in question. The state's governor has asked the department to engage in a reduction exercise for the remainder of the fiscal year, in the area of a 6% reduction. This would total $112.8 million in across-the-board cuts. For the next biennium, a 10% reduction above current projections is being called for.

Cuts in many optional benefits will begin on Jan. 1, 2011, although several will require legislative action during the 2011 session. Those cuts would take effect in March 2011. The cuts include a $39.4 million savings by placing limits on adult pharmacy services, $8.3 million from adult dental services, and $3.3 million for interpreter services.

Conceivably, some non-Medicaid programs will need to be eliminated. "Under national health reform, those individuals would be in Medicaid tomorrow," says **Roger Gantz**, policy director for Washington Medicaid. "We are in a dual process of having to build a new system for 2014, while simultaneously having to strategically reduce the existing health system for low-income individuals today."

Some targeted rate reductions were made during the last fiscal year. "We are also in the process of seeking an 1115 demonstration waiver to be able to sustain several of our key state-only medical programs like the Basic Health program," says Mr. Gantz. "That combination, plus tax increases, allowed us not to have made any material benefit design reductions."

The problem is that all of the near-term options to reduce costs have already been implemented. While there are potential cost savings from health homes or other quality initiatives, these won't be seen in the short term.

"The reality of better coordination of care is bending a cost curve or trend, as opposed to actual savings on the short term," says Ms. Lindeblad. "Perhaps we will see that on a long-term basis, but we cannot bank on it in terms of balancing the budget."

While the Medicaid program is seeing an increase in total expenditures, this isn't on a per-capita basis. The real cost driver has been on the caseload side of the equation.

For the next two years, a significant increase is expected in coverage for children, through the Apple Health for Kids program. By the end of the next biennium, 45% of all children in the state will be covered by Apple Health. "This is good news and bad news," says Mr. Gantz. "More children will be getting health coverage, but the question is, are we really going to see a dent in children's insurance rates? We don't know the answer to that, because that growth could be coming from a degradation in the employer-sponsored market."

An increase in the Temporary Assistance for Needy Families (TANF) population is expected to continue for the next biennium. "We are seeing a steady growth in coverage for the elderly and disabled in the 3% to 4% range. That will continue in the next biennium," says Mr. Gantz. "So, nothing is going down. Everything is going up."

An independent analysis of health care reform's impact on Washington state is under way. Two big concerns are takeup rates and adverse selection, with high-utilizers expected to come on to the program first. "But in general, we think the uninsured population that is out there is lower than our existing Medicaid population," says Mr. Gantz.

Opportunities on horizon

The governor is calling for continued efforts to improve efficiency in the health care system, across all state purchasing. This includes not only the Medicaid program, but also purchasing for public employees.

Legislation passed in 2008 gives incentives for reducing emergency department use and hospitalizations. "Clearly, health reform complements those efforts. Certainly, they are in philosophical sync," says Mr. Gantz. "We are also being asked to continue to improve efficiencies in the purchasing of prescription drugs."

An all-payer database will require some up-front investment that won't be recouped until several years out, he says. "The governor understands that and is willing to commit some front-end investment to do that," says Mr. Gantz. "But quite frankly, that investment doesn't compare to that of a complete new Medicaid eligibility system. The dollar amounts are appreciably different."

Washington has a multipayer workgroup, which has been meeting for the past year, including the major insurers, Medicaid, and the Health Alliance. "This group has put together some options around the different payment mechanisms for medical homes," says Ms. Lindeblad. "We are going to be piloting that. We are in the middle of making the choice of which practices are going to be allowed to participate."

In addition to changing the structure of how payments are made to health homes, a set of performance expectations is being developed. These strategies will strengthen the use of the state's Preferred Drug List and increase the use of generic utilization. "We are starting that effort now. In order to accomplish that, our state might need to seek additional waivers," adds Mr. Gantz.

Systems challenges

A major concern is having the necessary infrastructure in place to comply with the requirements of health reform. "There are two basic pieces to that," says Mr. Gantz. "One is delivery system capacity. Our view is that managed care expansion is going to be a vehicle to help develop that network capacity."

The other concern is systems capacity, particularly in the Information Technology arena and the state-level Health Insurance Exchanges (HIEs) that will allow individuals to purchase coverage. "The big piece around that is coordination of eligibility with the Medicaid program, vis-a-vis the exchange," says Mr. Gantz. "The set of expectations that exist there are all very laudable and all very desirable — and all present some very interesting challenges."

The state intends to use its $1 million planning grant to determine what functionality the exchange needs to have, and what functionality Medicaid needs to have, according to Gantz. An initial assessment is being done of the Medicaid eligibility systems capacity.

"What it may lead to is a decision for whether we will build the Medicaid functionality required by health care reform off our existing Medicaid system, or a new system," says Mr. Gantz. "Given the time constraints, the foregone conclusion is probably going to be building off our existing system. But we still have to go through that process of asking those questions and attempting to answer them."

Another challenge involves building a continuum of care between Medicaid and the entities operating the HIEs, which will be certified health plans. "This is one of the more interesting challenges in all of this," says Mr. Gantz. "We are beginning the conversations with health plans about the possibility to operate in both a Medicaid environment and a health exchange environment, as beneficiaries move between Medicaid and the exchange."

This continuum would ensure that when an individual loses Medicaid eligibility, he or she doesn't "fall off a cliff" with providers or plans. "We have to talk more about what that continuity strategy would actually look like," says Ms. Lindeblad.

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Connecticut Medicaid sees many fiscal opportunities with reform

Michael P. Starkowski, commissioner of Connecticut's Department of Social Services, says that he sees "opportunities galore" in the health care reform legislation. "We are looking at a number of initiatives that are coming down the pike; some of those have pros and cons," says Mr. Starkowski.

Adding smoking cessation to the Medicaid package, for example, will have a cost benefit in the long run. However, in the short term this represents an additional cost to the state, he notes.

Two years ago, Connecticut carved out all pharmaceuticals from its programs. "We handle those collectively as an agency," says Mr. Starkowski. "Every one of our programs has a pharmaceutical benefit, even though based on the program, you may have a copay or an annual cap."

All drugs are pooled through the department using a Preferred Drug List, and they are reviewed and decided on by a pharmaceutical and therapeutics committee. "We already receive a supplemental rebate from the manufacturers. In this department alone, we spend somewhere in the range of $400 million on pharmaceuticals," says Mr. Starkowski.

Altogether, 48 possible opportunities for the state were identified in health care reform. "Some are requirements and some voluntary; some we may apply for and some we may not, but we are trying to look at this in aggregate," Mr. Starkowski says. "We are looking at medical homes. We are looking at multistate initiatives. We are trying to take every single one of the initiatives seriously, and figure out whether it is advantageous to the state."

The state has found that the federal government and the Centers for Medicare & Medicaid Services are eager to move quickly with initiatives, he says. For example, with the high-risk pool initiative, there was a very short time frame for states to get their information together and make decisions.

"In some respects, this actually benefits the states. You have a short window of time to focus your resources, make a decision, and move on to the next issue," says Mr. Starkowski. "If you are allowed six or eight months to go through a process, the decision-making gets harder. It keeps popping up, but then it goes down to the bottom of the pile again and comes up another day."

More incentives

The state is interested in taking greater advantage of financial incentives for the transition of people from institutional care to community settings, he says. This is something that Connecticut has been working on for some time.

"We have a new — but robust — Money Follows the Person program. We have moved out 300 people from skilled nursing facilities back into the community," says Mr. Starkowski.

Previously, an individual had to be in a facility for six months to be transitioned, but this was decreased to 90 days. This is an advantage not only for the state, but also for residents, says Mr. Starkowski, as it's easier to move someone into the community who still has connections in place.

At the end of the day, will health care reform actually be self-sustaining for Connecticut? Mr. Starkowski says, "I think the jury is out. It has the potential to cost states significant amounts of money by increasing the rolls they are responsible for. In general, our first experiences have been positive. Whether those will continue for the next three and a half years, time will tell."

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

For outreach to newly eligible, consider reframing Medicaid as "new" program

States may have a fairly accurate picture of the number of individuals who will be newly eligible for Medicaid as of 2014, but getting them to actually enroll may be more difficult than expected.

"There will be challenges associated with trying to enroll this population," says **Robin Rudowitz**, MPA, a principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured in Washington, DC. "Historically, many low-income adults have not been eligible for Medicaid. They may have tried to apply in the past and been denied."

These individuals may not have any connections to other public programs, and there may be literacy or language barriers. "Some subgroups may be even more difficult to reach," says Ms. Rudowitz. These include individuals with mental health needs and younger individuals who don't see the immediate value of health coverage.

Rachel L. Garfield, PhD, an assistant professor in the Department of Health Policy & Management at the University of Pittsburgh Graduate School of Public Health, says that states face several challenges in reaching out to the newly eligible Medicaid population. "This population includes many different groups that may have different perceptions of and experience with Medicaid," says Dr. Garfield.

Some newly eligible individuals may have had previous contact with the program, either because they were previously enrolled, tried to apply in the past but were denied, or have family members served by the program.

"For this population, experts have stressed the importance of reframing the program as 'new,' to erase any misinformation that they are not eligible," says Dr. Garfield.

Other newly eligible individuals have had no or minimal contact with state Medicaid programs or state administrative systems in general. States will need to educate this group about the existence of the program.

"There is a lot of discussion about negative views of Medicaid and how these views dampen participation. But when surveys ask people if they would enroll if eligible, most say yes," says Dr. Garfield. "The key will be educating people that there is a new program, and that they are eligible for coverage."

Partnerships needed

Many states partner with providers or community agencies in their current outreach efforts. "These partnerships will be invaluable in getting out the message about the Medicaid expansion," says Dr. Garfield. "However, state Medicaid directors may need to consider bringing additional agencies into these arrangements to reach out to the newly eligible."

Rhonda Seltz is coordinator of Radford University's FAMIS (Family Access to Medical Insurance Security) Outreach Project. She says that Virginia's Department of Medical Assistance Services works very hard with statewide community partners to simplify the application process. Better coordination with outreach efforts for the state's FAMIS and Medicaid programs is another goal.

"With the recent downturn in the economy, however, eligibility worker caseloads at most local Departments of Social Services have more than doubled," says Ms. Seltz. "This overwhelming increase in demand for services certainly cries out for the need for more workers and resources at local agencies."

More state-supported outreach and education efforts with employers are needed. "One of the most challenging types of outreach I have encountered is trying to sell the program to employers," says Ms. Seltz. "Employers and employees could greatly benefit from allowing families the opportunity to sign their children up for Medicaid or FAMIS."

With the average price of a family plan costing more than $1,000 a month, an employee with FAMIS or Medicaid-eligible children could bring home a much bigger paycheck that does not deduct a full family plan premium, according to Seltz.

"Healthier children would translate into less missed days at work, and may even allow the employer to be eligible for less expensive employer-sponsored coverage, if sick children are not part of the employer policy," says Ms. Seltz.

Ms. Rudowitz notes that "along with eligibility expansions, there are a whole series of requirements on coordinating health care enrollment."

A person may be applying for coverage through the HIE with income that makes him or her eligible for Medicaid. In this case, there must be a process in place to put that individual into the right program, Rudowitz says.

"There is a new requirement for uniform income rules to determine eligibility for Medicaid and for the exchange," says Ms. Rudowitz.

Culture change is needed

Michael Perry, a partner at Lake Research Partners, a Washington, DC-based national public opinion and political strategy research firm, has researched innovative Medicaid enrollment processes for the Kaiser Commission on Medicaid and the Uninsured. Based on interviews he has conducted for this project, he says that one key is having "visionary Medicaid leaders who have been working on modernizing systems and streamlining enrollment for the last few years."

"This takes a long time," says Mr. Perry. "States which have not been working on this will have a tough time in 2014."

Another key factor is forming good relationships with community partners. This will help vulnerable and non-English speaking populations to enroll in the program. "There also needs to be a will to change the culture of eligibility workers, so that they welcome applicants rather than treat them badly and try to keep them out of programs," adds Mr. Perry.

The sheer size of the expansion is daunting. "We're looking at tens of millions of adults who will become eligible for Medicaid for the first time," says **Benjamin D. Sommers**, MD, PhD, an assistant professor at Harvard School of Public Health in Boston. "This will significantly strain the enrollment and renewal systems that states are using." It requires major infrastructure investment in the next three years to prepare for 2014."

Outreach efforts will need to reach individuals who are quite distinct from the traditional Medicaid population. "They will be primarily . . . adults who are not disabled and who do not have young children at home," says Dr. Sommers. "Most will have had fairly little experience with Medicaid and with social welfare programs in general."

It's not enough just to get individuals enrolled. They may need help finding providers who will see them. "This will likely be more difficult than for the current Medicaid population, which at least to some extent, already knows how the program works," says Dr. Sommers.

Make it easier to apply

Dr. Sommers says that one top priority should be making the application process straightforward and accessible through multiple avenues. People will need to apply by telephone, online, and through provider-assisted applications.

This process needs to work seamlessly with the state-level HIE, since many individuals will transition back and forth between Medicaid and the exchange as incomes fluctuate, he says.

"There are many low-income parents who have children already in Medicaid or CHIP [the Children's Health Insurance Program], and who now for the first time will become eligible for Medicaid themselves," notes Dr. Sommers.

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Kiosks may improve self-management of health conditions in Georgia

A Personal Health Advisor kiosk is being piloted in Georgia's Early County by the Georgia Department of Community Health and Atlanta's National Health Museum. Residents can now access current, personalized health assessments.

The kiosk is located in the waiting area of the Blakely, GA-based Primary Care of Southwest Georgia. It is a freestanding digital system that allows users to access five health modules on healthy weight, diabetes prevention, blood pressure, vaccination, and sexual health. The kiosk is designed to be user-friendly for adults at all education levels, and for those with limited technology experience, according to DCS spokesperson Lisa Marie Shekell.

Users choose a health module of interest, enter non-identifiable demographic data, and answer health status questions. The kiosk's touch-prompt screen features two physician "tour guides" to help patients answer questions about their health and health knowledge.

Within several minutes, users receive a custom risk assessment printout, action-oriented tips for healthy living, and local and national health resources. To protect user privacy, no personal information is collected.

Early County was identified as an ideal location to launch the program because of the community's significant health care needs, the existence of strong community resources, and a growing health care service-delivery environment, says Ms. Shekell.

The goal is to empower health care consumers to make informed decisions about their health care and lifestyle habits. "The Personal Health Advisor kiosk is an innovative tool that utilizes user-friendly technology to bring health education and health risk assessments to a community in rural Georgia that is struggling with poor health outcomes," says Ms. Shekell.

The touch-prompt screen, plus the sight, sound, and motion used present an engaging user interface. "Plus, it's easy-to-use regardless of one's technology experience or education level," says Ms. Shekell.

Providers may find that access to the kiosk is a valuable resource for their patients, because it offers an opportunity to address their health issues. It will also serve as a patient education tool, by offering local citizens an opportunity to use technology to learn about healthier lifestyle choices and the conditions that disproportionately impact them, she says.

"The ultimate goal is to have a positive impact on health outcomes in the community, while introducing the benefits of health technology," says Ms. Shekell. "While future expansion depends upon the availability of funding resources, we have begun to identify ways to further utilize this technology to benefit both the provider and patient."

Increasing the variety of health modules reviewed on the Personal Health Advisor kiosk is one option. Other possible topics include electronic health records, pregnancy, student health, top-performing athletes, and nutrition.

"While we do not have current funding to launch a second Personal Health Advisor kiosk, we are exploring the potential of moving the kiosk for a temporary period of time to other communities across the state," says Ms. Shekell.

Contact Ms. Shekell at (404) 657-9118 or lshekell@dch.ga.gov. ■

Medicaid mortality rates significantly higher after major surgery

Medicaid patients had higher mortality after major surgeries than other patients, according to *Primary Payer Status Affects Mortality for Major Surgical Operations*, a new study from researchers at the University of Virginia Health System in Charlottesville. The study was published in the September 2010 issue of *Annals of Surgery*.[1]

From 2003 to 2007, 893,658 major surgical operations were evaluated using the Nationwide Inpatient Sample database, including lung resection, esophagectomy, colectomy, pancreatectomy, gastrectomy, abdominal aortic aneurysm repair, hip replacement, and coronary artery bypass.

The researchers found that patients with Medicaid payer status had a higher risk of in-hospital mortality and complications. Medicaid patients accrued higher costs compared to uninsured and Medicare patients, even after accounting for patient risk factors.

"We do not believe there is a simple explanation," says **Damien J. LaPar**, MD, the study's lead author and a surgery resident physician in the Division of Thoracic and Cardiovascular Surgery at the University of Virginia.

The researchers accounted for many potential factors that may impact surgical outcomes, such as patient health and co-morbid diseases, socioeconomic status and income, regional hospital differences, and race. Despite these adjustments, Medicaid patients had the highest odds of mortality among Medicaid, Medicare, private insurance, and uninsured patients.

"Discrepancies in patient outcomes as a function of payer status are likely due to subtle, complex interactions between a number of patient and health system-related issues," says Dr. LaPar. For example, these patients may have more advanced disease when they present, may have a limited support network after surgery, and may be getting their care at different centers compared to other patients.

Reasons are complex

Terry Conway, MD, a Chicago-based principle of Health Management Associates and former chief operating officer of the Ambulatory and Community Health Network at Cook County Bureau of Health Services in Chicago, notes that the compared outcomes in this study were for serious surgeries that are likely to be done to non-pregnant adults, which is not the major population that is in Medicaid. Also, people with serious illnesses often go onto Medicaid because of their condition, which is not the case with Medicare and commercial insurance.

"There are significant differences there. Medicaid is coverage that people characteristically go on and off of," says Dr. Conway. "So, the people in Medicaid were likely to have not been covered for a long time and have underlying illnesses. That was controlled for, but what wasn't controlled for is how well they were cared for in the past. So, these differences could be due to how well this population was treated."

Another possibility is that the providers or hospitals that did the surgery were not high quality or lacked the resources of facilities that see primarily Medicare and commercial insurers, Conway says.

"Given that Medicaid enrollees have a number of characteristics that put them at a higher mortality risk, it is not surprising that they experience higher mortality rates, even after adjusting for the comorbidity measures that are available on the hospital discharge abstract," says **Genevieve M. Kenney**, PhD, a senior fellow and health economist at The Urban Institute in Washington, DC.

However, Dr. Kenney notes that the study does not include a full set of controls for socioeconomic status and related health risks. "Therefore, the study does not take into account the possibly confounding factors that are likely linked to Medicaid enrollment," says Dr. Kenney.

Dr. Kenney points to greater poverty rates among Medicaid enrollees and their much higher rates of mental and physical health problems as likely contributors to their higher mortality rates.

"In addition, relative to Medicare and private-pay patients, Medicaid patients may be receiving care from different hospitals and/or surgeons, or may be receiving a different mix of services and procedures," says Dr. Kenney.

ID root causes

Dr. Kenney says that future research should be aimed at sorting out the roles played by unobserved health risks and other related risks, by differences in the mix of hospitals and surgeons treating Medicaid patients, and by differences in the mix of services provided to Medicaid surgical patients.

"It will be important to narrow the study population to a group that is more homogenous than the one studied here, so as to develop an appropriate comparison group for the Medicaid patients who were studied," says Dr. Kenney. "And it would also be important to look at within-hospital mortality rates to identify root causes of mortality differences."

While Dr. Kenney doesn't think

that the study provides conclusive evidence of a causal link between payer source and mortality, she says that the paper indirectly raises a number of important questions related to hospital-based patient safety and quality of care that are of importance to Medicaid programs.

"It brings out the importance of carefully controlling for the characteristics of the Medicaid population and the providers they use, when comparing their service use and outcomes to that of other payers," says Dr. Kenney.

Patricia MacTaggart, a lead research scientist and lecturer in the Health Policy Department at George Washington University in Washington, DC, says that in general, the study authors address variables that are consistent with other studies, such as volume being an indicator of quality.

"The study discussion also acknowledges identified limitations that are critical for analysis," notes Ms. MacTaggart. For instance, many elderly and disabled Medicaid are "dually eligible" for Medicare and Medicaid, and these were counted in only one payer source in the study.

The study also acknowledges that the data source accuracy is limited by the fact that many Medicaid enrollees gain their eligibility retroactively as a result of their hospitalization. "Thus, Medicaid individuals may not be tracked in the correct category," says Ms. MacTaggart. "More importantly, they may have had less preventive care coverage than someone who had Medicare or private insurance coverage prior to the hospitalization."

Most states have been analyzing high-cost, high-utilization inpatient services based on their Medicaid data for some time, says Ms. MacTaggart. "What is added in this study is the comparison data from other payers," she says.

Various states utilize Medicare Hospital Compare, The Leapfrog Hospital Survey, Healthcare Cost and Utilization Project, and the Healthcare Effectiveness Data and Information Set measurement data to do similar analyses and comparisons for the hospitals in their states in order to make decisions regarding coverage and payment.

"While inpatient hospital coverage has a significant immediate cost impact on Medicaid, outcomes of inpatient hospital stays have an even more substantial impact on Medicaid costs long term," adds Ms. MacTaggart.

Improve quality

"Medicaid directors and policy makers should be aware of these findings, including the fact that major operations in these patients appear to be more costly," says **Gorav Ailawadi**, MD, senior author of the study and faculty member at the University of Virginia's Division of Thoracic and Cardiovascular Surgery.

More importantly, Medicaid payer status may serve as a proxy for larger, health care system-related issues that could be targeted to improve surgical outcomes for Medicaid recipients. Further identification of "culprit factors" may help to improve patient morbidity and mortality following major surgical operations, for both Medicaid and uninsured patients, explains LaPar.

"We would likely require prospective data to identify opportunities for improvement," adds Dr. LaPar.

Dr. LaPar says that patients and physicians should "know and understand the influence of primary payer status during preoperative patient risk stratification." He would like to see further investigation of this complex issue aimed at identifying modifiable factors to improve patient outcomes.

"Look at what is happening nationally now. People are looking at reorganizing the way care is delivered," says Dr. Conway. For example, accountable care organizations are paid extra if they achieve quality — but save costs. This is mostly happening in the Medicare and commercial world, however, while uninsured and Medicaid patients are seen at health systems known as the "safety net" says Dr. Conway.

"This is not a high-quality approach, and it is an expensive approach," says Dr. Conway. "This population had worse outcomes and a longer length of stay. If I were a Medicaid director, I would try to expedite the safety net by looking into building delivery systems that would produce accountable care."

Dr. Conway notes that the fact that more money is spent doesn't necessarily mean that health status improves. "You've got to do more specific things, and they have to happen within the delivery system," he says.

Medicaid needs to become more involved in the transformation of the safety net medical delivery system, as is being done in the Medicare and commercial world, says Dr. Conway.

"It looks like, too, in the future, that even CMS [the Centers for Medicare & Medicaid Services] itself would like to see the safety net do this more; but they can't do it alone, because Medicaid is not strictly a federal program," says Dr. Conway. "Start looking at the delivery system that you provide payment to, and see what you could do to foster more accountable care."

Dr. Kenney says that it will be important for states and local areas with large projected Medicaid enrollment increases in 2014 to address provider capacity issues. "Those gaining Medicaid coverage in 2014 will likely be subject to many of the same disadvantages that may be contributing to the results of this study," she says. "Therefore, it will continue to be important to evaluate program performance with these caveats, and to identify Medicaid policies that help families successfully overcome access barriers."

As "meaningful use" measures move forward, hospitals will provide additional standardized mea-

surement results across payers. This will provide another data source for quality initiatives, beyond the tools currently available.

Medicaid agencies and hospitals will be targeting hospital-acquired infections and addressing payment limitations required under new federal law, says Ms. MacTaggart. "Information such as this could be valuable, even with the limitations, not necessarily in comparison to other payers, but as a source of additional information across payers," says Ms. MacTaggart.

Ms. MacTaggart says workforce demand is one of the biggest potential concerns of state and federal Medicaid leaders in preparation for 2014 expansions, particularly related to specialists. "This study just highlights why focusing on this potential issue is critical. Targeted strategies are needed," says Ms. MacTaggart. "For this particular area, '2014 is now.'"

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How accurate are Medicaid projections on expansion population?

Health care reform "is extraordinarily complex — a massive, truly unprecedented social experiment," says **Kip Piper**, MA, FACHE, president of the Health Results Group in Washington, DC. "As Rick Foster, the CMS [Centers for Medicare & Medicaid Services] Chief Actuary, has correctly pointed out, there really is no way to precisely estimate enrollment."

The Congressional Budget Office projects Medicaid expansion will add 16 million enrollees by 2018, while CMS' Office of the Actuary projects 20 million new enrollees.

"With an aggressive outreach campaign by HHS [the Department of Health and Human Services] and states, the Medicaid expansion population could easily reach 23 million," says Mr. Piper.

However, enrollment of newly eligibles will vary greatly by state, he says. For example, because of relatively low current Medicaid eligibility levels and higher than average rates of uninsured, Medicaid enrollment in Texas will increase by 1.8 million to 2.5 million, California between 2 million and 3 million, and Florida between 950,000 and 1.5 million, says Mr. Piper.

"In contrast, states with low levels of uninsured and broader Medicaid coverage will see modest expansion of Medicaid rolls," says Mr. Piper. "Massachusetts is likely looking at 30,000 to 75,000 more Medicaid eligibles."

Many factors at work

The number of newly eligibles coming onto the program will depend on outreach, how individuals and employers respond to the new federal mandates, the health of the economy as of 2014, levels of crowd out, interplay between Medicaid and State Exchanges, and many other factors, Piper says.

"The factors are also interactive, making projections harder," says Mr. Piper. "Crowd out of employer-sponsored insurance is inevitable. This will be significant and is likely to grow over the first few years of Medicaid expansion."

At least 30% of the new enrollees will move from private insurance coverage to Medicaid. "In other words, if Medicaid expansion to 133% FPL increases Medicaid enrollment by 20 million, only about 14 million will be newly insured," says Mr. Piper. "Crowd out will vary considerably by state."

The internal projections of states will be continually refined as we get closer to implementation, as HHS releases rules and guidance, and as economic conditions evolve, says Mr. Piper.

"Because of enhanced federal match, Medicaid expansion will hit state budgets more in the out years," says Mr. Piper. "Administrative costs will hit states more immediately."

Showcase best practices

States will need to make a massive array of changes to Medicaid policies and systems, build capacity to handle the huge volume of applications, and adapt Medicaid managed care programs to serve the expansion population through benchmark plans, Piper says.

This must happen at the same time they build state Health Insurance Exchanges, and create linkages between Medicaid, the Children's Health Insurance Program, and HIEs for eligibility and subsidy determination, he says.

"Therefore, enrollment projections will be critically important to planning and budgeting for administrative costs," says Mr. Piper. "There will be many unhappy governors and state budget directors when they hear about the cost of implementation."

The newly announced higher federal matching funds available for Medicaid-related systems for

HIEs and Medicaid expansion will help. "But federal funds for states to implement exchanges is limited, and likely to become more restricted during Congressional appropriations battles," notes Mr. Piper. "States must operate exchanges at their own expense, either through state budget, taxes, or user fees."

Pent-up demand

Many new Medicaid eligibles will come from the long-term uninsured. "They will have pent up demand for services, a pattern of avoiding care and relying on emergency rooms, and a serious need for preventive and primary care," says Mr. Piper.

The primary care capacity may not be adequate to handle the influx of newly insured. "Patient education, wellness programs, cultural competency, language competency, and medical homes will be essential," says Mr. Piper. "It will be a challenge, but Medicaid expansion is a great opportunity for states and Medicaid health plans to showcase the many best practices built up in recent years."

As systems of care are developed for the expansion population, these need to take into account that many individuals will bounce between Medicaid eligibility and the HIEs from year to year, he says.

"Ideally, Medicaid health plans will also participate as Qualified Health Plans in exchanges," says Mr. Piper. "This would allow individuals to stay in plans and maintain continuity of care; the benchmark benefit designs will be very similar."

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California Medicaid saving millions with progressive anti-fraud efforts

California's Department of Health Care Services' (DHCS) anti-fraud program is regarded among the top programs in the nation, reports department spokesman **Anthony Cava**.

A September 2010 proposed rule from the Centers for Medicare & Medicaid Services (CMS) would strengthen fraud oversight in Medicare, Medicaid, and the Children's Health Insurance Program.

"CMS has approved and been supportive of our anti-fraud efforts, and through its recently proposed rule is allowing other states to follow California's lead," says Mr. Cava. "We currently practice all of the fraud prevention measures specified in the rule." Here are some current practices, according to Cava:

- Usage trends are analyzed by beneficiaries and providers, to confirm that services are not being obtained or provided in a fraudulent manner and that services claimed have been delivered.

Currently, DHCS is engaged in sending 500 beneficiary contact letters to determine if these beneficiaries received a wheelchair, and if it is the one for which DHCS paid. "This practice has been fruitful," says Mr. Cava. "Based upon beneficiary response, DHCS may further investigate physicians and durable medical equipment providers."

- The provider enrollment process was tightened by developing new regulations that provide specific requirements for enrollment.

These include requiring providers to have an established place of business, developing new applications that obtain additional information about the provider and the business, and developing new provider agreements with clear language regarding Medi-Cal program compliance.

"One of the key elements of the enrollment and re-enrollment efforts is a background check. An onsite review of providers by DHCS Audits & Investigation is done prior to enrollment," says Mr. Cava.

- Focused reviews are conducted of provider types.

In September 2006, 2,000 pharmacies throughout California were visited and reviewed for compliance by DHCS staff. Similar reviews were done of Adult Day Health Care providers, durable medical equipment suppliers, and physicians billing for intrauterine devices.

"DHCS is constantly striving to improve its anti-fraud efforts by maintaining a highly trained staff, keeping abreast of the latest fraud trends and schemes, and utilizing the latest technologies and techniques designed to detect, identify, and eliminate fraud, waste, and abuse within its programs," says Mr. Cava.

Fraud prevention tool

The Medi-Cal Payment Error Study (MPES) is a fraud prevention tool used to continuously assess and monitor emerging trends, make informed decisions on the allocation of fraud control resources, and identify where the Medi-Cal program is at greatest risk for payment errors.

"The primary objective of MPES, implemented annually since 2004, is to detect, identify, and prevent fraud and abuse in the Medi-Cal program, gauge the seriousness of the problem, and develop appropriate fraud control strategies," says Mr. Cava.

MPES 2007, the most recent report, found that 93.44% of reimbursements paid to fee-for-service Medi-Cal providers in 2007 were billed appropriately and paid accu-

rately. This represents an improvement from the 92% accuracy rate of 2006.

"The 6.56% error detected in the 2007 MPES represents a $1.05 billion potential loss to the program," reports Mr. Cava. "Of the total claims reviewed, 2.53%, or $405 million, were found to have characteristics of potential fraud. This is lower than the 2.75% found in the 2006 study, which represented $445 million in payments."

DHCS performs investigational and routine field compliance audits to identify provider claim errors, take appropriate corrective actions, and apply appropriate sanctions. Patterns are reviewed, cases are developed, and sanctions are placed on providers who submit claims with errors or characteristics of fraud.

"Currently, all errors identified in MPES 2007 are being reviewed to determine if follow-up reviews on audits should be conducted," says Mr. Cava.

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New rapid test identifies active TB

Test may improve early detection

A new rapid tuberculosis test promises to help reduce health care worker exposures through early identification of patients.

The test, called Xpert MTB/RIF, can be performed in less than two hours. In a study involving 1,462 patients with suspected TB, the test correctly identified 98% of those with culture-confirmed tuberculosis and 98% of those with drug-resistant tuberculosis. It also correctly ruled-out tuberculosis in 99% of the patients who did not have TB.

The test isn't available yet in the United States — it isn't approved by the Food and Drug Administration — but already TB experts are touting its prospects.

"The goal right now is to recognize the people who have the symptoms of tuberculosis and to make a presumptive diagnosis and put them in isolation. In the United States, I think they're doing a pretty good job [of doing that]," says **Gerald Mazurek**, MD, captain in the U.S. Public Health Service and medical officer and epidemiologist in CDC's Division of TB Elimination.

However, there's always a risk that the symptoms of TB will be misconstrued for another respiratory illness and that other patients and health care workers could be exposed before the patient is placed in isolation, he says.

The Xpert MTB/RIF amplifies the nucleic acid in a sputum sample and can identify sensitivity to rifampin, an anti-viral. The test can therefore indicate not only whether a patient has TB, but whether he has a drug-resistant strain. ■