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In This Issue

Is dropping out of Medicaid a serious consideration for states?

Charles Duarte, administrator of Nevada's Division of Health Care Financing and Policy, says that in January 2010, state Gov. Jim Gibbons asked staff members to explore whether the state could drop out of the Medicaid program.

"The reason we did the report was to examine options," says Mr. Duarte. "Given Nevada's budget shortfall, which is one of the worst in the nation on a percentage basis, Medicaid was becoming unsustainable."

If this continued unchecked, says Mr. Duarte, Medicaid spending would continue to consume a larger and larger percentage of state revenue, supplanting funding for other important government services, such as K-12 education, higher education, and public safety.

However, Mr. Duarte says that Medicaid termination is "not a serious consideration for Nevada. Federal rules and court actions have severely curtailed states' ability to manage spending in Medicaid."

Limited ways to control spending

States have limited "tools" available to control spending in the near term, says Mr. Duarte. These include reductions in eligibility

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DC Medicaid revamps its fraud detection processes

Did a dentist extract the same patient's tooth twice, or extract teeth the year after they gave the patient upper and lower dentures? These are obvious red flags for fraud, while other types of fraud are less easy to identify, says **Ann Page**, RN, MPH, director of Health Care Accountability Administration for Washington, DC, Medicaid.

"We have revamped our processes. We are a small jurisdiction, and we are just trying to clean up and tighten up the program," reports Ms. Page. "I'm pleased to say that over the last three years, we have tripled the amount of potential fraud we have detected and referred out."

Extra emphasis

Health care reform legislation puts extra emphasis on fighting fraud and abuse, notes Ms. Page, along with the Center for Medicare & Medicaid Services' new proposed rule to strengthen Medicaid fraud oversight.

Fiscal Fitness: How States Cope

"Health care fraud is a concern

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State Health Watch
The Newsletter on State Health Care Reform

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Cover story

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and provider reimbursements, service limitations, and elimination of "optional" services, says Mr. Duarte, but federal Maintenance of Effort requirements under the American Recovery and Reinvestment Act and the Patient Protection and Affordable Care Act (PPACA) have restricted states from limiting eligibility.

Eliminating optional services, such as personal care attendant services or prescription medications, tends to shift spending to other parts of the program, adds Mr. Duarte, while reimbursement reductions can sometimes lead to access issues.

"There are also potential legal and regulatory restrictions related to elimination of optional services or rate cuts that may have an impact," says Mr. Duarte. "The bottom line is that states are finding their ability to manage Medicaid more and more difficult."

Another concern that led Nevada to analyze the impact of Medicaid termination, says Mr. Duarte, was the fiscal impact of the PPACA. The most significant obstacle to dropping out of Medicaid, he says, "is the economic impact on the eligible recipients and the health care industry in the state. There would be no health safety net for hundreds of thousands of Nevadans and a significant loss of revenue to the health care industry. In other words, it would affect lives and livelihoods."

Mr. Duarte expects that some states will examine the possibility of global "block grants" for Medicaid. "However, those aren't the panacea some states hoped they would be," he says.

This leaves state Medicaid directors, says Mr. Duarte, "between a rock and a hard place."

Not fiscally possible

Judith Solomon, co-director of health policy at the Center on Budget and Policy Priorities in Washington, DC, says that Nevada, Wyoming, and Texas all analyzed the possibility of Medicaid termination. All three states, she says, "concluded that dropping out was not something the state could afford to do."

Dropping out of Medicaid would cause Texas to lose $15 billion in federal funding, and up to 2.6 million Texans could become uninsured, according to the December 2010 report prepared by the state's Health and Human Services Commission: *Impact on Texas if Medicaid Is Eliminated*.

"The others also found a detrimental impact," says Ms. Solomon, adding that state discussions over terminating Medicaid began largely as a result of a 2009 report from The Heritage Foundation in Washington, DC, *Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion*.

"The report suggested that states could drop out, use the state funds spent on Medicaid to address the needs of people with disabilities and seniors, and allow other individuals to move into the insurance exchanges to be set up by states," says Ms. Solomon. "There has been a debate about whether or not that is even feasible, and we think it's not."

Ms. Solomon says that the PPACA is clear that individuals with incomes below the poverty line cannot receive premium credits for the insurance exchanges, with the exception of legal immigrants who have been in the country for less than five years and can't get Medicaid.

"That was one problem that states encountered, and that is . . . more of a long-term issue for 2014," she says. "States have also looked at dropping out of Medicaid in the short-term.

Wyoming took it down almost to the beneficiary level in examining the impact of dropping out in its report."

Wyoming's analysis, says Ms. Solomon, looked at individuals receiving care in various institutional settings and what it would mean to pull them out of Medicaid. "They found that this could not be done without significant harm, not only to their overall budget, but also to the health of their residents," she says.

Numerous obstacles

Michael Sparer, PhD, JD, department chair and professor of health policy and management at Columbia University's Mailman School of Public Health in New York City, says that if states want to get off Medicaid, they face serious fiscal and political obstacles.

"Certainly, the key fiscal issue is the potential loss of Federal Financial Participation [FFP] dollars, which for many states would be a huge and difficult budget blow," says Dr. Sparer.

What some state officials are arguing or suggesting, says Dr. Sparer, is that they could potentially make up for some of those dollars if they could transfer their beneficiaries into the new insurance exchanges. The argument is that these beneficiaries would receive some subsidies anyway, perhaps full subsidies, depending on their income, explains Dr. Sparer.

"Number one, it is not clear if states would be able to do that," says Dr. Sparer. "It is simply not clear if Medicaid beneficiaries would be eligible for federal subsidies in the exchanges, if a state eliminated its Medicaid program."

Secondly, even if states were able to do this, there is still the issue of long-term care to consider, says Dr. Sparer. "A big chunk of state Medicaid expenditures these days, and an important role for state Medicaid programs, has to do with being a safety net for the nation's long-term care system," says Sparer. "You couldn't make up for that money with the exchanges."

For this reason, Dr. Sparer says that the fiscal losses of FFP dollars are "a huge obstacle."

There is also a set of political obstacles, adds Dr. Sparer. "Clearly, as much as the provider community often finds fault with the Medicaid program, if tomorrow all of those Medicaid beneficiaries were suddenly uninsured, there would be strong concern in the provider community for how to make up for that revenue loss," he says. Dr. Sparer adds that there would also be a significant political backlash from the provider community and advocates for the beneficiaries.

Despite these obstacles, Dr. Sparer says that there are policymakers in some states who would definitely like to get their state out of Medicaid, and they are looking into the pros and cons of doing so. "They are talking about the need for states to get away from the overburdening, micromanaging federal oversight, and see this as a way to do it," he says.

Even those who are in favor of dropping out of Medicaid generally have a clear understanding of the obstacles involved, adds Dr. Sparer. "They are now looking to see if they can come up with strategies to counteract those obstacles," he says. "Do I think at the end of the day states are going to do it? At this point, I would say no. I think that the obstacles are too large."

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Fiscal Fitness

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across the entire health care industry. It is not a problem unique to Medicaid," says Ms. Page. "It's a problem, and it's a pretty big problem, at a time when budgets are very tight."

Ms. Page says that state Medicaid agencies are currently faced "with really bad choices that nobody wants to make. Do we cut back on services, or do we cut back on people?"

This makes it even more important that Medicaid is not wasting any money, says Ms. Page, and is paying only for services that are really needed, and paying only people who are delivering those services.

"The department has been thinking about this for a long time, and when the department got realigned, it decided to dedicate a whole administration to this," says Ms. Page. The department's new Health Care Accountability division covers program integrity, looking at both fraud, waste, and abuse — and utilization management.

Specialized functions

The department looked closely at how to make the best possible use of its staff to prevent fraud. "One of the things we've been trying to focus on is how do we deploy the people that we have here to make sure we are paying for services appropriately," says Ms. Page. "We want to identify outright fraud when it does exist, but sometimes providers just make errors. They are human like everybody else."

Errors are not always a sign of intentional wrongdoing and can occur, because providers are just trying to deal with the complexities of billing correctly — sometimes even because the department hasn't paid them correctly, explains Ms. Page.

While some staff specifically look for fraud, others do reviews of providers to be sure that all billing was

completed appropriately and correctly, says Ms. Page.

"We take both of those approaches; we try to find both intentional wrongdoing and accidental errors," says Ms. Page. "One of the things we have done is specialize those two functions."

One investigation unit is now dedicated to identifying fraud, says Ms. Page. "Under federal regulations, we are not the party that conducts the full criminal investigation," she notes. "What we are required to do, and what we are limited in doing by federal regulations, is to conduct a preliminary investigation."

This means that when the department uncovers reasonable, reliable evidence of likely fraud, it is then required to refer this to law enforcement to pursue criminal action, says Ms. Page.

Data mining is key

"We pay millions, maybe over a billion, of claims a year," says Ms. Page. "It is not possible to review all of those. So, how do we creatively identify what types of fraud are likely to occur?"

One important point, says Ms. Page, is that fraud can be committed by all different types of providers. "We will find providers that have billed for a service, and when we contact the beneficiary, they say they didn't get the service and never saw the provider," she says.

The department also enlists the public's help by publicizing its toll-free number to report fraud, so that individuals can call in to report things that don't seem right to them, says Ms. Page.

Effective fraud detection calls for "imagination and creativity" in investigators, coupled with technology, says Ms. Page. While the investigative unit is heavily dependent on computers, she says, investigators have to be clever to determine all of the possible ways in which fraud could be taking place.

Ms. Page adds that the department plans to take advantage of the free training being offered by the federal government's newly created Medicaid Integrity Institute.

Ms. Page credits her department's success in tripling the amount of fraud it detects largely to the technique of data mining. "We are doing a lot of data mining, and we are getting more sophisticated with it," she reports. "I would have to say that if we are looking at combating fraud, data mining is how we are doing that. That is the key."

At-risk providers

"We are trying to prevent fraud up front," says Ms. Page. "One of the ways we are trying to do that is to prevent bad apples from getting into the program to begin with."

The department first focused on durable medical equipment (DME), because this was identified as an at-risk provider type, says Ms. Page. A DME provider enrollment reform initiative was implemented, with more stringent requirements. All DME providers were contacted, and informed that they are required to reapply and re-enroll in the program, says Ms. Page.

"We will require them to re-enroll every three years," she adds. "Just because they met requirements in year one doesn't mean that later on, something hasn't changed."

DME providers are now required to be enrolled in the Medicare program. "If you are not serving older adults, then that's going to limit your ability to serve our population," says Ms. Page. "We view that as a pretty fundamental requirement. Maybe you have done something that has caused you to lose your Medicare enrollment. That has implications for us, and you would be terminated from our program."

About 30 DME providers already on the books didn't re-enroll, and these providers were terminated as a result, says Ms. Page. "Some of them may no longer have been in business. Others have tried to re-enroll but could not meet the standards," she says.

In 2010, the department implemented a new Medicaid Management Information System, which allows for more targeted data querying, says Ms. Page, and gives reports that are utilized for protection against fraud and abuse. Certain information, such as the rank order of providers and how many services they billed for, can pinpoint the need for further investigation, she says.

"If last year a provider billed Medicaid half a million dollars, and this year that provider is billing $2 million, you will want to look at what is going on," says Ms. Page. "How did their Medicaid income quadruple in one year?" In this case, investigators would want to know whether there was a commensurate quadrupling of services, or whether more expensive procedures were used, she says.

Without this type of claims data, says Ms. Page, fraud detection efforts are "not going to be very fruitful." While the department has always had the ability to look at claims data, the new software allows data to be retrieved and manipulated more easily, she explains.

This allows investigators to analyze larger amounts of data, she says, so they can focus on at-risk provider types, for example, rather than looking at every Medicaid provider type. "They can review what is happening in the field. If there is dental fraud happening in one state, they can look at whether it is also happening here," says Ms. Page.

If law enforcement agencies ask for more information for an investigation, the department can easily supply it, explains Ms. Page. "They may say to us, 'You gave me three months of claims data. We want to see three years,'" she says.

Contact Ms. Page at (202) 478-5792 or ann.page@dc.gov. ■

Battles will continue, over both Medicaid expansion and the mandate

The argument of some state policymakers, says **Michael Sparer**, PhD, JD, department chair and professor of health policy and management at Columbia University's Mailman School of Public Health in New York City, is that the federal government is significantly increasing its oversight of the Medicaid program and its demands on state Medicaid officials; "and they believe strongly that that's the wrong way to go."

"And, of course, it also gets into politics," says Dr. Sparer. "You have many Republican governors out there who are opposed to health care reform in just about all of its forms." A number of states are suing the federal government currently, not just over the mandate, but also the Medicaid expansion itself, he notes.

Interesting legal argument

"The legal argument over the Medicaid expansion is interesting," says Dr. Sparer. "One of the things that states are claiming in the litigation is that the expansion is illegal, because it in effect requires the states to incur these additional costs."

The federal government has responded that states are, in fact, not required to do so, Dr. Sparer explains, because they do have the option to drop out of the program. "The states' response is, 'We can't simply drop out of Medicaid in 2011 after having to been in it for 50 years,'" he says. "Were a state to actually drop out, which I don't think is going to happen, that actually would end up helping the federal government in the litigation."

Dr. Sparer says that he thinks that repeal of the Patient Protection and Affordable Care Act (PPACA) is "extremely unlikely, at least before 2012. If there were a Republican-elected president and a Republican-controlled Congress, that is a whole different ball game," he says.

On the other hand, Dr. Sparer says, we can expect to see battles over appropriations for certain aspects of health care reform. "Whether it's Congress, the courts, or states, it's going to be ongoing political battles on a whole host of things," he says. "The implementation itself is long and arduous and difficult, and will inch forward as it's doing now."

As for the battle of public opinion, Dr. Sparer says this appears to be a stalemate. "I would say most Americans have a limited understanding of what is in the legislation itself," he adds. "It's such a complicated bill, and politicians are saying different things, so how the issue is framed is all up for grabs."

At the same time, Medicaid directors are trying to stay out of the legal and political battles, to the extent that this is possible, says Dr. Sparer. "Generally speaking, Medicaid directors are an extraordinarily professional and high-quality group of folks who are just trying to do their jobs," he says.

If the federal government says they have to expand Medicaid, they are going to figure out how to do so, says Dr. Sparer, and if the governor of their state tells them to cut costs, they are going to try to do it while running the highest-quality program they can. "They have a very tough job," he says. "I don't think there are many jobs in the U.S. that are tougher than being a Medicaid director in 2011. They are just trying to do it one day at a time."

Call for more flexibility

Judith Solomon, co-director of Health Policy at the Center on Budget and Policy Priorities in Washington, DC, notes that while states have concluded they can't drop out of Medicaid, they still want additional flexibility. "For example, Rhode Island's former director of Health and Human Services has touted the Rhode Island waiver as an example of a block grant approach," she says. "I think we will see more and more of those kinds of arguments."

States are arguing that they should be allowed to spend Medicaid money as they see fit, says Ms. Solomon. "States already have a lot of flexibility in the law. Federal minimum standards protect beneficiaries by, for example, giving them the right to appeal if service is denied," she says. "We think that giving the money to the states and letting them decide how to use it is not the right approach."

Two separate issues

It is important to remember that the challenges involving Medicaid expansion and budget deficits currently faced by states are two separate issues, according to Ms. Solomon. "The lion's share of the 2014 expansion will be paid by the federal government. The increase in state spending, over and beyond what they would have spent, is 1.5%," she says. "And that does not take into account the state-funded services that will now be eligible for federal reimbursement."

Ms. Solomon notes that many of the childless adults who are not receiving Medicaid get mental health and other services, all of which would be eligible for federal reimbursement.

"It's important to recognize that the expansion is really a good deal for states as well as the people, many

of whom are receiving services now in states," she says.

Ms. Solomon points to the Center on Budget and Policy Priorities' October 2010 analysis, *Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law*. "This shows that reports have overestimated the costs to states," she says, adding that previous studies have had similar findings.

"During the last recession, there were similar arguments made about Medicaid busting state budgets," says Ms. Solomon. "But when things turned around, you saw states expanding coverage, certainly for children."

Ms. Solomon acknowledges that many state Medicaid programs have cut benefits and provider rates, but points to a January 2011 report from Washington, DC-based AARP, *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports*. According to the report, 31 states cut non-Medicaid aging and disability services programs in FY 2010, and 28 states were expecting to cut these programs in FY 2011, while states are "holding steady" with Medicaid long-term services and supports.

"I think that states understand that when you are cutting Medicaid, you need to make deeper cuts to save state dollars, because of the federal match," says Ms. Solomon. "When you lose the federal match, you are losing money that would have otherwise come to states." ■

Medicaid offering participant-directed long-term care services

To date, 240 programs with more than 800,000 participants offering participant-directed services as a delivery option in long-term care services have been located by the research team of **Kevin J. Mahoney**, a faculty member at the Boston College Graduate School of Social Work and director of the National Resource Center for Participant-Directed Services in Boston.

Participants in all of the 240 programs exercise employer authorities, such as hiring one's own worker, and/or budget authorities, where one can manage the entire budget involved in their health care, including hiring workers or purchasing goods and services that help maintain their independence in the community, according to Mr. Mahoney.

The programs offer home and community-based services that help people of all ages across all types of disabilities maintain their independence, says Mr. Mahoney, and determine for themselves what mix of personal assistance supports and services work best for them.

"The growth of these programs accelerated in the 2000s, as the findings of Cash & Counseling influenced changes in the Medicaid waiver application process," says Mr. Mahoney. "This made it easier for states to develop and implement participant-directed programs."

New opportunities

Mr. Mahoney adds that he is anxiously awaiting draft regulations from the Center for Medicare & Medicaid Services on the Community First Choice Option, a new state plan option to provide home and community-based services in Medicaid.

"We pray that they will allow participants significant flexibility in purchasing goods and services, even if they cannot use these funds to purchase expensive home modifications and assistive technology," says Mr. Mahoney.

Given the enhanced federal match, Mr. Mahoney says that it would be "a blow to participant direction" if the budget authority is not allowed to the full extent possible.

Participant direction is a major component of the new Community Living Assistance Services and Supports (CLASS) Act, notes Mr. Mahoney, which was passed as part of national health care reform.

"The CLASS Act has the potential to dramatically improve quality of life for millions of Americans with disabilities, by establishing a national, voluntary, long-term care insurance program that provides money to people who want to maintain their personal independence," says Mr. Mahoney.

Slow, steady increase

When Georgia first introduced participant-directed care into its waiver programs, the state experienced "high activity," says **Catherine Ivy**, deputy director of the Division of Medicaid's Aging and Special Populations Section.

Since that time, says Ms. Ivy, there continues to be a slow but steady increase in the use of the model. "The increase has been most prevalent in the waivers that serve younger individuals with disabilities and individuals with developmental disabilities," reports Ms. Ivy. "The interest among the older adult population has been stronger than we anticipated."

The entire long-term care service delivery system has become more participant-directed, says Ms. Ivy, as a result of the new cultural norm that began with this model of care delivery.

"The participant-directed model

of service delivery has already resulted in many Georgia waiver participants becoming more astute consumers of long-term care services," Ms. Ivy reports.

Ms. Ivy notes that the model is fully integrated in Georgia, with participants engaged in traditional employer activities such as training, supervising, and managing their caregivers." "Our hope is that we are encouraging the development of savvy consumers of health care in general," she says.

Launches succeed

Despite numerous challenges, many states have developed successful strategies for implementing consumer-directed long-term care service programs, according to an article, "New State Strategies To Meet Long-Term Care Needs," published in the January 2010 issue of *Health Affairs*.[1]

"Quite frankly, we were gratified, and somewhat surprised, that all 12 of the states that received cash and counseling replication grants succeeded in launching programs," says **Pamela Doty**, the study's lead author and a senior policy analyst in the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services in Washington, DC.

Four states received grants in the first Cash & Counseling Demonstration and Evaluation, notes Ms. Doty, but one dropped out prior to implementation and returned the unspent funds to the Robert Wood Johnson Foundation.

"That state could not go forward because, operationally, local county agencies had a great deal of autonomous control over the organization and delivery of Medicaid-funded community-based long-term services and supports," explains Ms. Doty.

After several large counties announced they would not participate, other counties pulled out, says Ms. Doty, and the counties that still wanted to go forward didn't have enough potential clients to meet caseload requirements for the demonstration.

"We thought something like this might happen in some of the replication states, so we were quite concerned that we might lose two or three states," says Ms. Doty.

Many moving parts

Innovation in Medicaid-funded home and community-based care programs usually requires multiple state agencies to work together, according to Ms. Doty. This is because Medicaid agencies typically delegate operation responsibilities for these programs to state units on aging, state developmental disabilities agencies, or agencies that focus on services to younger adults with physical disabilities or specific kinds of injuries, such as traumatic brain or spinal cord injuries, she explains.

These agencies, in turn, often delegate to regional or county agencies and to private, non-profit organizations, such as area agencies on aging, says Ms. Doty.

"In sum, there are many moving parts," says Ms. Doty. "That's even before taking into account the traditional services providers, such as home care agencies, adult day treatment centers, and so forth."

These traditional service providers are often for-profit entities that may fear losing business if Medicaid beneficiaries choose to self-direct their services and employ individual providers of aide services directly, adds Ms. Doty. Here are three trends in participant-directed care that Ms. Doty is seeing:

• States are relaxing previous restrictions on family members becoming paid caregivers.

"The evidence in favor of relaxing restrictions goes beyond the positive findings associated with paying family caregivers in Cash & Counseling programs," according to Ms. Doty.

She refers to the findings of a July 2008 study, *Analysis of the California In-Home Supportive Services Demonstration Program*, sponsored by the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Researchers compared outcomes program participants who employed non-relative personal care attendants or family members. "The study found positive results associated with employment of relatives, including employment of spouse and parents of minor children, as paid caregivers," says Ms. Doty.

• States are continuing to add participant-directed services, primarily within their 1915(c) waiver home and community-based services programs.

Ms. Doty refers to the Washington, DC-based Westchester Consulting Group's 2001 inventory of Medicaid and other publicly-funded state-level programs offering self-directed services options, ASPE Consumer-Directed Support Service Program Inventory, which found 139 programs with an estimated 500,000 participants.

• Managed care plans are including participant-directed services options.

"TennCare recently added Choices for Long-Term Care, which includes opportunities for self-direction," notes Ms. Doty.

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REFERENCE

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Patients becoming more involved with care of chronic conditions

Forty-six states are actively building delivery and distribution systems to ensure that programs in chronic disease self-management are readily available to individuals with chronic conditions, especially older adults, says **Sue Lachenmayr**, MPH, program associate at the Center for Healthy Aging in Washington, DC.

In the past few years, most states have received federal grants so that state public health and Medicaid agencies can implement the Palo Alto, CA-based Stanford Patient Education Research Center's Chronic Disease Self-Management Program, notes Ms. Lachenmayr.

"It is vital for Medicaid directors and providers of services to the chronically ill to know more about this valuable resource," she says.

The program can improve quality of life, maintain good health, and delay or minimize the debilitating effects of chronic diseases, says Ms. Lachenmayr, as well as providing potential cost savings.

Ms. Lachenmayr says that participation in chronic disease self-management programs has grown, and the expectation is that it will continue to grow even more in the coming years. "Some states are already piloting medical homes and including community-based chronic disease self-management programs as a patient activation strategy," she says.

In this program, says Ms. Lachenmayr, individuals learn and practice strategies that help them to be better self-managers and improve their ability to communicate with health care providers.

Fewer admissions, ER visits

Alaska Medicaid contracts with a Quality Improvement Organization (QIO) that helps patients get appropriate care and teaches self-management, according to **Jon Sherwood**, medical assistance administrator at Alaska's Department of Health and Social Services.

"The contract is limited and targets patients where their assistance is expected to have the greatest outcomes," says Mr. Sherwood. "It helps these patients avoid emergency room and inpatient hospital admissions."

The state's public health agency currently offers a limited diabetes self-management program, adds Mr. Sherwood. "The state of Alaska is currently evaluating the medical and health home options included in the ACA [Affordable Care Act]," he says. "Self-management would be a component of those options."

The Maryland Department of Aging is the main provider of chronic disease self-management programs across the state, according to nutrition and health promotion programs manager **Judy R. Simon**, MS, RD, LDN.

The program "Living Well: Take Charge of Your Health," targets seniors and began in 2006, says Ms. Simon. Since then, it has expanded to 16 of the 19 statewide area agencies on aging across Maryland, she notes, and a "Living Well with Diabetes" program was added.

"Living Well has grown over the years," says Ms. Simon. "Our programs have reached a total of over 1,500 seniors across the state."

In 2010, the Living Well program received additional funding from the American Recovery and Reinvestment Act to target low-income, Medicaid-eligible seniors and other vulnerable groups, Ms. Simon reports.

"We are in the planning stages of coordinating our outreach efforts to this population," she says. "To date, we've begun a cross-referral process with the Delmarva Foundation's Every Diabetic Counts (EBC) program."

Delmarva Foundation is a federally designated QIO for Maryland, currently under contract to the Centers for Medicare & Medicaid Services to improve the quality of health care for Medicare beneficiaries, says Ms. Simon.

"The Living Well Program is a great compliment to the medical model of the EBC program," says Ms. Simon. Living Well focuses on self-management strategies to allow participants to integrate the information they receive in their EBC classes into their day-to-day lives, she explains.

"We've also begun a partnership with Federally Qualified Health Centers (FQHCs), which provide services to the Medicaid population," reports Ms. Simon. "As a result, the number of medically underserved population, which our program serves, will begin to grow exponentially."

While The Living Well program targets seniors, the FQHC will be devoting resources in order to reach all age groups, she explains. The agency is also partnering with statewide and local organizations, health clinics, local health departments, and hospitals that serve Medicaid-eligible seniors, notes Ms. Simon.

"In addition, we are launching a statewide outreach campaign about all of our services, entitled '3Ps: Planning, Prevention, and Preparedness,'" which will have significant media involvement," says Ms. Simon.

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Surprisingly, many young uninsured are risk-adverse

Many young and healthy uninsured individuals don't see themselves as invincible and in fact are risk-averse, according to a December 2010 study by the Washington, DC-based Center for Studying Health System Change (HSC).

"Contrary to what a lot of people often assume about the uninsured who are young and healthy, the study found that many do not perceive themselves as invincible, or that they can get by without insurance," says study author **Peter Cunningham**, PhD, a senior fellow and director of quantitative research at HSC.

This could mean that these individuals will be motivated to gain coverage through the state-based insurance exchanges, which will be created as a result of the national health reform law, says Dr. Cunningham. His study, *Who Are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges?* offers these key findings:

• About half of the uninsured consider themselves to be risk-averse, including those who are healthy and have no negative experiences with the health care system.

• Most uninsured individuals believe that they need health insurance, although fewer believe that it is worth the cost.

This could change, however, once premium subsidies are available in 2014, notes Dr. Cunningham. "The findings indicate that cost and affordability dominate the decision not to get health insurance, rather than the perception among some uninsured that they don't need it," he explains.

These findings have implications for eligibility and enrollment in the new state health insurance exchanges, according to Dr. Cunningham. "Those who are responsible for setting up the exchanges will need to realize that the individual mandate alone will not guarantee enrollment," he says.

Outreach and streamlined enrollment will be necessary to reach the healthy uninsured, says Dr. Cunningham, "although outreach strategies will probably be very different than for Medicaid."

Many individuals on Medicaid enroll at the time that they actually need health care, notes Dr. Cunningham, and continuous open enrollment in Medicaid ensures they are able to do that. Medicaid also doesn't require any premium payments, so there is no cost to enrolling for the patient, regardless of whether they need care immediately or not, he explains.

"For the exchanges, it will be a much more challenging task to get the uninsured enrolled in something that they may not immediately need, but will have to pay for anyway," says Dr. Cunningham.

However, the federal government will require defined open enrollment periods, notes Dr. Cunningham, which means that people will only be able to enroll in the exchanges at certain times of the year. "Hopefully, this will help by getting people to think about the financial risks of not enrolling if they have an unexpected health problem," says Dr. Cunningham.

Contact Dr. Cunningham at (202) 484-4242 or PCunningham@hschange.org. ■

Medicaid programs making headway with medical homes

Over the past year, eight states — Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia — have been working with the National Academy for State Health Policy (NASHP) to develop medical home programs in their Medicaid and Children's Health Insurance Programs.

"This period of technical assistance that we provided to states came at a very challenging time for them," reports **Mary Takach**, MPH, RN, the lead researcher on NASHP's Medical Homes II Consortium project. "All were struggling with budget constraints, and many had to cut their Medicaid programs."

States worked on forming partnerships, defining and recognizing medical homes, reforming payment, supporting practices, and measuring progress, says Ms. Takach. While budget constraints did slow progress in some states, she says, things continued to move forward.

"It didn't stop their efforts. States still seemed very committed to pushing ahead," says Ms. Takach. "Many are extremely hopeful that the funding for medical homes in the PPACA [Patient Protection and Affordable Care Act] will help push things along at a faster pace."

Modest budgets

Ms. Takach holds up Nebraska as one example of a state that had a modest budget to launch its medical home program, and had to scale plans back substantially. "It is very modest. They are starting out with two practices," she says. "The interesting thing is that they are thinking ahead."

Nebraska has a state plan amendment in place for the Centers for

Medicare & Medicaid Services to review, which includes the fundamental developments in its pilot program, so that the state can take this to scale when new funding becomes available, explains Ms. Takach.

"A state like Maryland, which has a very tough budget situation, got legislation passed in a very short amount of time to get a multipayer effort going," adds Ms. Takach. "They were very innovative in the way they used community resources. They exploited some resources in their own backyard to get their medical home program going."

Despite not having a lot of state funding, she says, they were able to obtain support from commercial plans to help fund the medical home pilot.

Ms. Takach says that in fact, dire budget situations may be helping the growth of medical homes. "It really kind of forced states to look at ways to slow the growth cost in their Medicaid programs," she says. "I think that the budget situation has made medical homes rise to a level of high interest in legislatures and [with] governors."

Ms. Takach says that she was surprised to see New Jersey, a state that is facing significant budget constraints, pass legislation last year requiring Medicaid to start a medical home pilot. Part of the motivation for efforts like this, she says, is that states clearly see that what they are currently doing is not effective.

"The outcomes have been pretty flat in Medicaid programs, and costs are spiraling," Ms. Takach says. "They have been encouraged at results seen in other states with flattening the cost growth, increasing patient and provider satisfactions, and actually providing some quality outcomes in their Medicaid populations."

Programs are still new

Ms. Takach says that while there are a couple of states with robust medical home programs where the project is not convened by the state, for the most part, it is the state leadership that is key. "That is needed to galvanize the community stakeholders to really do the hard work that is needed to achieve those delivery system changes," she says.

There are very few states so far that have had the opportunity to scale up on a statewide basis, says **Anne Gauthier**, MS, a senior program director at NASHP. "The states that have done so are generally small states such as Vermont," she adds. "North Carolina has its program statewide, but as they add enhancements, they start in only a subset of counties and areas. It takes time to figure out how to implement innovations across the state."

Ms. Takach notes that the oldest medical home pilot is only two or three years old, and states are just beginning to think about making the transition to statewide.

In a new round of technical assistance, says Ms. Takach, NASHP will be working with states to find viable sources of funding to sustain medical homes beyond the pilot stage, add more payers, expand it to additional populations, and use resources available in the PPACA.

While states that already have medical homes in place have opportunities to bring in other payers, says Ms. Gauthier, states that aren't as far along still have the chance to take advantage of opportunities in the PPACA.

"The window doesn't shut; that's the good news," says Ms. Gauthier. "There will be funding when they are ready to move ahead."

Some states are waiting for the evaluation of the pilot that is under way to be completed, Ms. Gauthier explains, which will provide some impetus for them to begin their own programs.

Ms. Takach notes that the PPACA includes a new state option to provide health homes for the chronically ill, and this is available to states when they are ready to apply. In fact, she says, it may be easier for states to take advantage of this particular funding if they haven't gotten medical homes in place yet.

"It might be more challenging for states that already have programs going to retrofit their programs to take advantage of the funding," explains Ms. Takach. "For states that just haven't been able to mobilize around health homes yet, this is a perfect opportunity to test the waters."

Outcomes are encouraging

The medical home pilot projects were successful in preventing inappropriate utilization of services, such as decreases in ED utilization and readmissions, reports Ms. Takach. "Outcomes from patients are encouraging, too," she says. "Patients are getting more preventive services and screenings. There is good data around that."

Consumer satisfaction was extremely high with Oklahoma's medical home program, with complaints to the Medicaid department regarding the ability to access care dropping from thousands to a mere handful, notes Ms. Takach.

"They have been extremely pleased with seeing that kind of satisfaction among their Medicaid beneficiaries," she says.

Another positive development involved dramatic increases in provider participation rates in Oklahoma and Colorado, Ms. Takach says, which have very broad-based Medicaid medical home programs.

"You are asking Medicaid providers to do more. To become certified as a medical home is an extra hoop to jump through, and the payment incentive to do that is modest," says Ms. Takach. "It's not a lot of money, but providers like these programs and this new attention to quality."

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MassHealth's bundled payment approach: A "baby step" toward broader reform

An innovative pilot program in Massachusetts will soon be implemented, with the goal of improving the care of children with asthma, reports **David Polakoff**, MD, chief medical officer of MassHealth, the Massachusetts Medicaid program. "We hope to implement this as soon as possible," he says. "This is an idea that has been kicking around for awhile; it has been tried in some small-scale pilots."

One reason MassHealth chose to focus on this particular population, says Dr. Polakoff, is that children with asthma have been extensively studied. "They have been found to have high use of ERs and inpatient stays that appear to be avoidable," he says. "In other words, if there were a way to better control their asthma, they wouldn't need to be admitted or go to the ER."

Dr. Polakoff says that avoidable ER visits and inpatient admissions are "bad all around. It is bad for [the child's] health, it's disruptive to families, it's excessively expensive for payers."

Though a number of similar pilots exist, Dr. Polakoff says, MassHealth looked most closely at a grant-funded pilot done at Children's Hospital of Boston. "They studied a small population, essentially in one neighborhood," he says. "And [the results] were very positive. It reduced the use of ERs and the hospitalization rate."

Interestingly, says Dr. Polakoff, the pilot also resulted in some positive nonmedical outcomes, with fewer missed days of school for children and fewer lost work days for parents. Those both went down significantly, according to internal data from an evaluation done by the hospital. Overall, says Dr. Polakoff, the evidence was "convincing and powerful enough for us to want to replicate it on a larger scale."

Program pays for itself

The size of the pilot will depend on what MassHealth was allocated in the state's budget for FY 2011, says Dr. Polakoff. "There was a budget line for this pilot; we'll go as large as we can go within that budget," he says.

Dr. Polakoff says that one goal is to replicate the successful results of the Children's Hospital pilot with pediatric providers in other parts of the state. "We are interested in insuring that there isn't some magic ingredient that Children's has and no one else has — that it's the program itself, not the provider," he explains.

Dr. Polakoff says that he expects buy-in from the provider community, both because their pediatric patients will be getting better medical care and because the pilot will pay for in-home services that are not otherwise covered by most payers.

Community case workers and asthma educators will do home visits, says Dr. Polakoff, to educate the child and the parents on self-management of asthma. "There is a whole program to teach them to take better care of themselves," he says.

The case workers will educate children and families on self-management, the proper use of preventive medications, and the importance of adherence to medication regimens, says Dr. Polakoff, as well as occasionally providing HEPA filters for vacuums and other techniques to reduce allergens in the home.

"The cost savings will come from decreases in ER visits and hospitalizations," says Dr. Polakoff. "The pilot program suggests that this can pay for itself, and perhaps more."

Broader approach

The bundled payment will cover standard services, such as office visits and spirometry testing, and in addition, the in-home visits, which are not currently paid for. "So, the bundle will be larger than the cost of the usual services," says Dr. Polakoff. "That is the investment."

The fact that there is an up-front investment required may deter some states from pursuing a similar approach, notes Dr. Polakoff. "I think that is always a limiting factor, until a wider and more rigorously studied pilot demonstrates that it's

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self-funding," he says. "As soon as you prove that the ROI is real, then you can stop worrying about that."

Dr. Polakoff notes that the pilot was conceived before the passage of the Patient Protection and Affordable Care Act (PPACA), and is part of the broader approach that Massachusetts is taking for payment and delivery system reform.

"It is a baby step toward payment reform," he says. "It really ties in with the governor and the secretary [of Health and Human Services]'s commitment to moving toward a more global reform of our payment system. This is one small step. It is one bundle for one population."

Providers get more control

The bundled payment approach, says Dr. Polakoff, is a way of giving providers more control over the way health care dollars are spent. "We are giving them a sum of money to care for all aspects of one disease in one patient," he says. "If that works, and we expect it will work, it's a small step away from the 'widget' approach to paying for health care."

Providers would be paid to take care of patients in a broader sense, explains Dr. Polakoff, rather than paid to perform a particular service.

One challenge that Dr. Polakoff foresees for providers is identifying community case workers to work with. "They don't exist everywhere, so they may have to either find them or create linkages with providers that they don't currently work with," he says. "There will have to be a little bit of work done by the providers."

The hope is to distribute the pilot at least somewhat evenly geographically, says Dr. Polakoff, to avoid being "Boston-centric." "That is something we are going to have to look at," he says. Dr. Polakoff notes that most children with asthma anywhere in the state have a pediatrician affiliated with a hospital that provides pediatric care.

Once a population of participating asthmatic children who are covered by MassHealth is identified, providers will be sent a list of children in their practice who are part of the program, says Dr. Polakoff, so that asthma educators can begin doing outreach.

"We think of bundled payments as transitional toward global payments," says Dr. Polakoff. "This is a step in that direction."

If MassHealth is successful with this patient population, says Dr. Polakoff, the approach may be expanded to additional populations. He notes that there are numerous opportunities in the PPACA for trials of payment and delivery system reforms.

"For many of them, [the Centers for Medicare & Medicaid Services] hasn't even released the details of the opportunities yet," says Dr. Polakoff. "I am sure some of them will cover bundled payments, and we will be looking carefully at those."

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