State Health Watch
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The Newsletter on State Health Care Reform
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In This Issue

The battle is on to control soaring costs of Medicaid's chronically ill

Evidence is mounting that a very small group of high-cost chronically ill clients accounts for the lion's share of costs in Medicaid programs. "It's pretty well established that the majority of your expenditures are for basically 5% of the population, with over 20% of expenditures going to just 1%," says **Stan Rosenstein**, MPA, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director.

Controlling costs for this population, says Mr. Rosenstein, "is clearly where the focus needs to be, and states fully recognize that."

In addition, the newly eligible population coming onto the Medicaid program as of 2014 is expected to be sicker than the current Medicaid population, Mr. Rosenstein notes. Over 40% of uninsured people eligible to receive subsidies through the health insurance exchanges have chronic conditions, or report fair or poor health, according to a December 2010 study from the Washington, DC-based Center for Studying Health System Change, *Are the Uninsured Eligible for Premium Subsidies in the Health Insurance Exchanges?*

As for the high-cost population, "when you drill down into who these

*See **Cover Story** on page 2*

DE Medicaid looks to disease management for long-term savings

Not surprisingly, the biggest current fiscal challenge for Delaware Medicaid is the dramatic increase in enrollment over the past two years, according to **Rita M. Landgraf**, secretary of the state's Department of Health and Social Services.

The Medicaid program's total enrollment was 194,200 as of December 2010, which is a 25% increase over enrollment two years earlier, says Ms. Landgraf. "At the same time, we are facing a loss of enhanced federal funding at the end of June 2011," she says. "This means additional state funds will be needed just to maintain the current level of services."

Fiscal Fitness: How States Cope

Since Maintenance of Effort requirements in the Patient Protection and Affordable Care Act (PPACA) prohibit restricting eligibility, says Ms. Landgraf, the department is looking to benefits and provider rates to control costs.

Ms. Landgraf expects health care reform to bring an additional 17,000 to 25,000 people onto Medicaid,

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State Health Watch
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Cover story

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people are, most of them are very ill," says Mr. Rosenstein. "Many are at the end of their lives. Many have severe mental illness and chronic illness together. There are clearly better ways to manage their care."

Already bare bones

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 the "heart of the problem for state officials is that there are cross-cutting pressures around Medicaid. These are very difficult to solve."

On the one hand, says Dr. Sparer, there is pressure for Medicaid to be used as a vehicle for expanding access. "Medicaid is probably the most cost-effective way to provide care to the uninsured," he says. "Thus, it comes as no surprise that the PPACA [Patient Protection and Affordable Care Act] has such a significant Medicaid expansion as a way of providing coverage for some 16 million uninsured."

On the other hand, says Dr. Sparer, Medicaid is traditionally financed through a system where states have to pay a significant chunk of the costs. "States do have severe budget deficits at this time," he adds. "States have to think very seriously about how they are going to pay their share of the bill."

This adds to the challenge of how to cut costs, as Medicaid is a "pretty-bare bones program already," says Dr. Sparer.

"You could cut reimbursement, but Medicaid is already a pretty low payer, as providers would be the first to tell you," says Dr. Sparer. "There is not a whole lot to cut, and you wind up with huge political battles with providers over those cuts. So that is not such a great strategy."

While Medicaid programs can cut certain optional benefits such as dental, mental health, vision, and podiatry, says Dr. Sparer, states are not going to cut the high-cost benefits such as inpatient hospital care that would save significant sums.

In addition, he says, cutting optional benefits raises political problems with providers and beneficiaries. Doing this might actually end up costing the program more, adds Dr. Sparer, as when a Medicaid client doesn't get his or her mental health coverage and winds up in an ED instead.

"You can try to get at fraud and abuse, but it's tough to get significant savings around that," says Dr. Sparer. "You can try to do more managed care, you can cut prescription costs, or do more HIT. There are a whole host of strategies, but cutting costs is not easy to do."

Dr. Sparer says the Medicaid expansion will be a "very different proposition" depending on the generosity of the state's current coverage. "Some states will not have a very significant Medicaid expansion because the state already has pretty close to what the law requires," he explains. "Other states will see a huge expansion."

States will need to decide whether coverage will be through fee-for-service or managed care, and if managed care, what kind, notes Dr. Sparer. However, most importantly, he says, states are going to have to find ways to control the costs of chronically ill individuals with multiple conditions.

"That is probably the one arena in which states do have some ability to do something that could both improve the quality of care for the beneficiary and also save some money," says Dr. Sparer. "I would think that would be at the top of the agenda for states, going forward."

Excluded from managed care

Historically, chronically ill individuals have been excluded from

managed care, says Dr. Sparer. He notes that some pilot projects are currently under way that move this population into managed care.

"But when you scale those up, you end up with very different economic patient populations, and different cultural and political environments," says Dr. Sparer. "So that is very tough to do."

Most managed care organizations (MCOs) just don't have much experience managing the care of the chronically ill, says Dr. Sparer. "Medicaid agencies began by getting the mainstream commercial MCOs — the Aetnas and the Oxfords — to take on the Medicaid population. They were perhaps willing to take on the young and healthy, because those were the populations they served in the commercial market," he explains.

Politically, the elderly and disabled have both been resistant to managed care, adds Dr. Sparer, and these groups have more political influence than young welfare beneficiaries. "The early poster child of Medicaid managed care was the 12-year-old kid with a sore throat sitting in the ER for six hours. That, managed care could do something about—they could get a primary care doctor for that kid," he says.

Managing the care of chronically ill, mentally ill, substance-abusing individuals is far more difficult, says Dr. Sparer.

After MCOs started covering the young and healthy Medicaid population in the early 1990s, the realization was made that the biggest cost savings was not in that population, adds Dr. Sparer. "It was with the higher-risk chronically ill population," he says. "Now, they are struggling to try to figure out how to care for that population."

Early investment

States have to spend some money early on, in order to develop a good care management program, with the hope of saving money over the long term, Dr. Sparer says. "If a state is under huge fiscal pressure, it is going to pause before investing money in care management programs. They are under serious pressure to cut their costs, not increase them," he says. "That is definitely an obstacle."

Dr. Sparer says that it is difficult to explicitly demonstrate the cost savings that will come from care management of the high-cost Medicaid population.

"Part of the reason it's tough is that there are times when care management could actually cost you more," he says. "If you can really do effective care management of the diabetic, or the asthmatic, there is a lot of money to be saved there." On the other hand, says Dr. Sparer, Medicaid will spend more money on additional screenings and preventive services.

Regardless of the upfront costs, though, Dr. Sparer says that Medicaid programs are spending so much money on the high-cost chronically ill clients that they simply must pay attention to this population.

"There is no guarantee that these new programs are either going to work," says Dr. Sparer. "But I think states can save money, if they do this efficiently and well."

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Fiscal Fitness

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with the expansion of eligibility to 133% of the Federal Poverty Level (FPL) in January 2014.

Health benefit exchanges, in combination with changes in insurance regulations and government-administered programs, will offer individuals seamless and continuous coverage, says Ms. Landgraf. "Enhanced technology will benefit both the Medicaid program and private insurers," she adds. "Of course, developing that technology by January 2013 could bring its own challenges."

Currently, about 79% of the Medicaid population is enrolled in two managed care organizations, reports Ms. Landgraf. "We are exploring expanded managed care service delivery to our long-term care population, as a way to enhance community supports for this population," she adds.

Potential fiscal savings

Delaware qualifies as an expansion state under the ACA, says Ms. Landgraf, because eligibility was extended to all adults at or below 100% of FPL as part of a demonstration program implemented in 1996. "We will receive an enhanced federal matching rate for this group of individuals," she says.

For long-term savings, though, Ms. Landgraf says that "the most effective changes can be made with regard to lifestyle issues."

Delaware's Medicaid managed care programs currently provide disease management programs, including smoking cessation and obesity initiatives, notes Ms. Landgraf.

"The ACA provides for grant opportunities that would allow us to do even more," she says. "While they are not defined as disease management programs, there are a number of provisions or demonstration projects that may assist states in their efforts to improve the quality of health care."

Ms. Landgraf notes that the leading cause of death for Delawareans is heart disease, "with the actual causes of heart disease being tobacco, poor diet, and lack of exercise."

Obesity is the second leading

preventable cause of death, she adds. "In 2009, 36.1% of adults in Delaware were overweight, and an additional 27.6% were obese," says Ms. Landgraf. "Sadly, the numbers aren't much better for children."

In 2008, 17% of Delaware's children were overweight, with 24% considered obese, notes Ms. Landgraf, and in the period from 1990 to 2007, the number of obese adults in Delaware doubled. In 2009, 54,400 adults in Delaware were told they had diabetes, says Ms. Landgraf, and 36,000 were told they were pre-diabetic.

Studies show that a two-year window exists to keep a pre-diabetic person from developing the disease, says Ms. Landgraf. "If pre-diabetics undertake lifestyle changes allowing them to achieve a five-to-seven percent weight loss, we will reduce the onset of Type II diabetes by 58%," she says. "Strong financial benefits can be felt as well."

Today, medical expenditures in Delaware connected to obesity are $207 million, says Ms. Landgraf, with the cost of care related to smoking coming in at $473 million. Adults in Delaware diagnosed with diabetes have medical expenditures that are 2.3 times higher than those without diabetes, she adds.

"It is estimated that medical expenditure savings following a 50% reduction of prevalence in diabetes and high blood pressure, and the heart disease, cerebrovascular disease, and renal disease that accompany it, would be $33 million per year in the short run, and $92.4 million in the medium run," says Ms. Landgraf. ■

Medicaid takes the lead in creation of Health Exchange

Delaware's Medicaid agency has been designated as the lead agency for the purpose of administering federal funds for planning the state's health benefit exchange, reports **Rita M. Landgraf**, secretary of the state's Department of Health and Social Services.

"Because Medicaid is a public insurance carrier and our mandate is to integrate Medicaid with the private commercial market as part of the exchange, Delaware felt it seemed appropriate to have our Medicaid office apply for the $1 million grant to help create the exchange," says Ms. Landgraf.

Ms. Landgraf explains that the process will be a collaborative effort among several agencies, including the Division of Social Services, the Department of Technology and Information, and the Delaware Health Care Commission.

"We have developed a partnership with our Department of Insurance to collaboratively address planning issues," she adds. "As part of the planning process, we plan to host forums, roundtables, and focus groups with a variety of stakeholders."

These will include small business, private insurance carriers, brokers, and agents, says Ms. Landgraf, to provide input into the structure of the health insurance exchanges. "Delaware recognizes the significant scope of the health benefit exchanges, and potential impacts for various sectors in the state," she says. "Consequently, our goal is to widely involve key stakeholders in the planning process."

More accessible care

A Health Care Reform Steering Committee was formed under Ms. Landgraf's direction. This group includes representation from the governor's office, the Department of Health and Social Service, the Department of Insurance, The Department of Technology and Information, the Office of Management and Budget, and the Division of Revenue, she says.

"In addition, we have engaged the Delaware Health Care Commission as a vehicle for public exchange of information," says Ms. Landgraf. "We are currently involved in an environmental scan to assess the health insurance market and key demographics in the state."

Ms. Landgraf says that the biggest challenge with the health benefit exchange is probably the sheer magnitude of work that must be completed in a relatively short period of time.

"A variety of tasks must be completed, including legislative and regulatory changes, policy development, technology changes, training and education," says Ms. Landgraf. "In many cases, these activities are sequential in nature. It will be a challenge to have everything in place by January of 2014."

Ms. Landgraf says that ultimately, health care coverage will be expanded for many low- and moderate-income individuals and families. "We foresee a more seamless, transparent, and understandable health care system that is more accessible to consumers," she says.

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Iowa program targets the 5% most costly Medicaid clients

Iowa Medicaid's disease management program, implemented in July 2010, has a focus that's a "little bit unique," according to **Leslie Schechtman**, DO, medical director of Iowa Medicaid Enterprise, Member Services. "We used a stratification methodology."

The program targets the 5% of members believed to be the highest cost and highest risk, says Dr. Schechtman. These individuals, she says, get additional care coordination to improve the quality of care and member outcomes.

Stephen Saunders, MD, MPH, chief medical officer of APS Healthcare, a subcontractor for Iowa Medicaid, explains that while many programs target high-cost members, Iowa's program also considers which members are most likely to change behaviors, such as frequent ED use. "We look at which members have behaviors we think we can impact," he says.

For instance, a Medicaid beneficiary may not be going to a primary care physician as often as he or she should be, explains Dr. Saunders. "This change would improve care coordination," he says.

Obstacles to care removed

Participating members receive one-on-one education over the phone from a health coach, says Dr. Schechtman. "We do primarily telephonic outreach," she says. "We don't have nurses do home visits, but they could arrange for a social worker to come into the home."

Social workers can then coordinate with other family members, says Dr. Schechtman, in the event their assistance is needed to help with the proper care of the member.

"We try to remove any barriers or obstacles to them getting the care they need," Dr. Schechtman says. "It could be a medication management issue, or any other type of issue that could come into play that could impact their care."

Coaches ensure that transportation resources are in place, says Dr. Schechtman, and that appointments with physicians are scheduled and followed. They also address any educational gaps in the patient's understanding of his or her disease, and ensure medications are taken properly to avoid disease relapse, she adds.

"A health coach would query the member on an initial assessment to determine social needs and disease-specific issues," says Dr. Schechtman. "Then, a care plan is determined to assist the member in following the physician's recommended plan."

Fewer readmissions

Care managers coordinate with hospitals throughout the state, Dr. Schechtman says, so that members are contacted very quickly after being discharged from the hospital. "We make sure they have a good plan in place, and that they are following up with medication adherence," she says. "This reduces readmission costs."

Nationally, about 15% of hospitalized Medicaid members are readmitted within 30 days, notes Dr. Saunders. "To really impact these costs is a major target of our program," he says.

If a patient is seeing multiple physicians, the health coach helps the patient to establish one primary care physician to better coordinate his or her disease, says Dr. Schechtman. "Patients need one doctor they can count on to coordinate their care," she explains.

This could reduce admissions and readmissions, says Dr. Schechtman, because the patient's primary care physician assists with coordination of specialty care and community resources. "This avoids duplication of efforts and gaps in care," she says.

Seven health coaches make about 6,000 calls each month, Dr. Schechtman says, with a full assessment of the member's needs done on the first call. The health coach then sets up a time for a follow-up call, to review the things that were discussed.

"Our goal is to change behaviors. Our health coaches develop a good rapport with our members," says Dr. Schechtman. "A relationship develops, and that relationship keeps the continuity going."

"Impactible" issues

Dr. Schechtman says she found it somewhat surprising that so many of the participants used the ER as their primary care provider, and that many lacked a single primary care provider. "Those are two big areas that I like to focus on," she says.

The health coach is notified about members with "impactible" issues based on their medical claims, she says. For instance, a member may have had an ED visit in the last month, or have congestive heart failure and isn't taking an angiotensin-converting enzyme inhibitor, she says.

"A classic Medicaid example is someone with asthma who doesn't understand the disease very well and is not taking their medications regularly," says Dr. Saunders. "The health coach can work with them to understand that they need to take their long-acting medication every

day, not just when they start to wheeze. By then, it's too late."

Dr. Saunders adds that costs have been escalating for individuals with chronic diseases. "This is the reason why it's more effective to target a much smaller group," he says. "Many Medicaid beneficiaries are healthy and don't necessarily cost too much. The beauty of this is that at the same time, these folks get better care for their chronic disease."

Iowa Medicaid's lock-in program is an offshoot program for a population of 300, focusing on inappropriate ED utilization and medication misuse, says Dr. Schechtman. A patient may be getting narcotic medications from a lot of different providers, she explains.

"There may be drug-seeking behaviors," she says. "We lock them in to one provider, one ER, one hospital and one pharmacy. Through that, we hope to enforce a change in behavior."

ROI in first year

By targeting adults with chronic disease, says Dr. Saunders, it is possible to see a return on investment in the first year. "These are folks who are costing you money right now," he says. "You get a fairly quick return, because their uncoordinated care can be so expensive. A single hospitalization can cost thousands of dollars."

One obstacle is that the health coaches sometimes have trouble reaching members, notes Dr. Schechtman. "Iowa Medicaid's population is pretty transient," she says. "Keeping on top of locating them is oftentimes a challenge. We try to contact the provider's offices or pharmacies and health maintenance workers for updated contact information."

While the program itself is voluntary, and members do have the option to opt out if they choose, the majority of individuals who have been contacted have agreed to participate, Dr. Schechtman says.

"We do our best to coordinate our resources with all of the other resources in the state, including WIC and our partners who run the mental health and behavioral health components," she adds.

Significant cost savings are expected from the program, reports Dr. Schechtman, mainly due to fewer hospitalizations and emergency department visits.

"The savings will more than pay for the cost of the program," she says. "Increased care coordination will help with the expected 80,000 to 100,000 newly eligible Medicaid population in 2014, many of whom are currently uninsured with a chronic disease."

Contact Dr. Saunders at (800) 305-3720 and Dr. Schechtman at (515) 974-3201 or lschech@dhs.state.ia.us. ■

New Medicaid populations being integrated into managed care

For Medicaid programs that have good relationships with managed care contractors already in place, it's a "natural development" to add the population of seniors and people with disabilities, says **Alice R. Lind**, RN, MPH, senior clinical officer at the Center for Health Care Strategies (CHCS) in Hamilton, NJ. "The timing is right now, because budgets are tight."

Over time, states have had to add in a lot of requirements for the high-needs population anyway, Ms. Lind explains. "Even in the relatively healthy mom and kid population, there are children with mental health needs, and women with high-risk pregnancies," she says. "So most state managed care programs have been dealing with the disabled and chronically ill population for a number of years anyway."

Gradual phase in

CHCS provided technical assistance for California in developing its 1115 waiver, says Ms. Lind, which included a component for moving its Seniors and Persons with Disabilities (SPD) population, known as Aged, Blind and Disabled in other states, into managed care.

During the early planning for the waiver proposal, Ms. Lind says that key informant interviews were done with stakeholders to gather input on the best approaches to ensure a medical home for the SPD population. "We also looked at performance measures," she says. "The state is planning to look at changes in utilization, and how beneficiaries interact with health plans after managed care is implemented."

In June 2011, managed care will be implemented for the SPD population in California's Medicaid program, rolled out by the birth date of the beneficiaries, reports Ms. Lind. "They are planning on a one-year gradual phase-in, done by groups of beneficiaries as opposed to geographically," she says.

In most plans, the addition of the SPD population means that health plan services must meet new requirements, says Ms. Lind. For example, there is a requirement to determine whether the beneficiary is high or low risk, she says, and any high-risk member must have a Health Risk Assessment completed within a certain number of days.

"The plan must be well aware of what the beneficiary's needs are, and any deteriorating conditions," says Ms. Lind. The reason for the gradual phase-in, she explains, is so the health plans can meet the needs of the newly enrolled.

ID future care needs

"You don't want to give the plans 100,000 clients on the first day. They have a hard time staffing up to deal with a huge wave of people getting enrolled at once," says Ms. Lind. "They much prefer California's incremental method of rolling enrollment by birth month."

California had a voluntary enrollment option for managed care for the disabled population in place, says Ms. Lind, and this will now become mandatory. "They are making sure they have the right set of consumer protections in place," she says.

While there were existing requirements for provider's offices to be accessible, a facility site assessment will now be done, says Ms. Lind. "They are going from office to office to see whether it is accessible by a person with a wheelchair," she says. "Those findings are going to be made public on the health plan's website."

Previously, case managers helped members to find accessible offices, says Ms. Lind, but now this information needs to be readily available to a much larger group of people.

The state will share prior utilization about new members with the plan shortly after the person becomes an enrollee, reports Ms. Lind. "The health plans have gotten really good at using data to identify folks at high risk," she says. "Now they will have a year or two of historical data. It helps them identify future care needs, so they can do more active outreach."

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Medicaid's interest in health homes remains high

Health homes are a model of care that many states are very interested in moving toward, according to **Julia Paradise**, associate director of the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured (KCMU). Ms. Paradise is author of the January 2011 brief, *Medicaid's New "Health Home" Option*.

"States are moving in the direction of enhanced coordination of care, and linkages between both clinical and nonclinical services and medical and long-term services," she says. "This holds the potential to improve care, as well as produce savings over the longer term, for people with some of the greatest needs."

The enhanced federal match for health homes gives states a big financial incentive to improve care, says Ms. Paradise. "So there is a constructive convergence of financing and care goals," she explains.

Many states already have medical homes of some scale in place, notes Ms. Paradise. She adds that a recent guidance from the Centers for Medicare & Medicaid Services indicates they would welcome initiatives that build on those existing programs.

"Some states are well along the way to providing for the kinds of models that the health home envisions," says Ms. Paradise.

States can use planning grants to develop the necessary infrastructure, such as Health Information Technology, she adds, and conduct other activities necessary to implement health homes.

Ms. Paradise notes that in the most recent 50-state budget survey done by KCMU, released in September 2010, 33 states said they were likely to establish health homes.

"It's certainly true that these are challenging times for states," says Ms. Paradise. "The resource issues are tough, but the interest level is high."

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Medicaid MC moves from its "gatekeeper" reputation

In previous years, there was a widespread perception that the reason managed care was cost-effective was that services were restricted, according to **Alice R. Lind**, RN, MPH, senior clinical officer at the Center for Health Care Strategies (CHCS) in Hamilton, NJ. This was a largely undeserved reputation, she says, but it worked against managed care expansion.

"It's taken a long time to make the case that managed care is able to assist people in both getting the right preventive care as well as coordinating care more effectively," says Ms. Lind. "That can lower costs without providers in any gatekeeping role."

California Medicaid sees managed care expansion for its Seniors and Persons with Disabilities (SPD) beneficiaries as a way to improve quality and access while containing cost growth, says Ms. Lind. Managed care clients will be in a health home, with better coordina-

tion of services and one person to call for health care needs, she says, whether a primary care physician or care manager.

The rates that California Medicaid is proposing to pay the managed care plans assume a reduction in emergency room and hospital use, adds Ms. Lind. The health plans and the Department of Health Care Services discussed this back and forth, she says.

"Plans initially took a look at those rates and said that they cannot achieve changes in behavior on the very first day of enrollment," says Ms. Lind. "But the plans are very comfortable assuming those changes will happen over time."

Access is an issue

For a subset of the SPD population with rare conditions, there may not be a single health plan that contracts with all the subspecialty providers that the individual needs, says Ms. Lind. Also, many SPD beneficiaries will have anywhere from three to nine different conditions, she adds.

"Finding the right set of providers who can see them for a broad range of conditions can be a challenge," she says.

Over time, in Medicaid programs across the country, managed care has moved away from the gatekeeper role that used to be assigned to the primary care provider, adds Ms. Lind.

"When states first started using managed care for the [Temporary Assistance for Needy Families] population, you would have to clear it through the primary care provider for every single referral," she says. "That doesn't work for this population with chronic and complex needs."

This is because seniors and adults with disabilities typically have long-standing relationships with an array of providers, says Ms. Lind, so it is no longer in the health plan's interest to require referrals. "The main thing that advocates and clients worry about is access to care," she says. ■

HCBS poised to expand: Wait lists reveal large unmet need

States have some good fiscal opportunities to expand home- and community-based services (HCBS) in the Patient Protection and Affordable Care Act (PPACA), according to **Charlene Harrington**, RN, PhD, FAAN, director of the University of California—San Francisco's National Center for Personal Assistance Services. However, an initial investment is required to set up the programs, says Dr. Harrington, and states face budget shortfalls.

The January 2011 AARP report, Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports, showed "a pretty steady trend upward" in HCBS, notes Dr. Harrington. "But there are these huge waiting lists in states," she says. "That is a big concern. It obviously shows there is a lot of unmet need."

Lawsuits putting pressure

The current financial crisis may mean that some states can't take advantage of the opportunities to expand HCBS, says Dr. Harrington. However, there is no question that states face "tremendous pressure" from their constituents to do so, she says.

There are also lawsuits in 34 states currently, says Dr. Harrington, which are putting additional pressure on states, and most court rulings have been in favor of the plaintiffs. In 1999, the Supreme Court ruled that individuals have the right to live at home or in the community if they are able to and choose to do so, rather than to be placed in institutional settings by the government, notes Dr. Harrington. That decision resulted in a number of subsequent lawsuits against states, she explains, which are putting additional pressure on states to "rebalance" their services from institutional to HCBS.

"The lawsuits are primarily for failure of state Medicaid programs to provide adequate HCBS, to prevent individuals from being institutionalized unnecessarily," says Dr. Harrington. Some of the lawsuits are against states that had placed large numbers of individuals into institutions and have failed to help those who want to go to home and community settings, she explains.

In addition, says Dr. Harrington, it's a violation of the Americans with Disabilities Act to keep people in institutions if they can be in the community. "The momentum is on the side of the plaintiffs," she says.

Savings are possible

Expanding HCBS programs isn't necessarily going to cost states more money, according to Dr. Harrington. "In fact, we've shown over time that the states that have expanded the most saved the most money," she says.

States can probably save some money by implementing HCBS programs, says Dr. Harrington, as long as they control the admission to the nursing homes. "The fear is that these new options will be implemented, but the nursing homes will still be filled," she says. "That would cost them more money."

For this reason, many states put some controls on their nursing home

admissions, and then try to set up a program so people can stay in the community, says Dr. Harrington.

The PPACA gives some significant financial incentives for states to implement HCBS programs, adds Dr. Harrington. "States can get an increase in federal match, but they still have to come up with the money to get the federal match," she says. "The question is whether the financial crisis will prevent them from doing this."

If states want to take advantage of the new opportunities, she explains, they have to increase the amount they spend in order to get the match, and this may not be possible.

States may in fact, choose to cut HCBS because they are optional programs, says Dr. Harrington. "States may do this when money gets tight, but I don't think they have explored the overall implications," she says.

Cutting HCBS programs costs the state more in terms of ER visits and hospitalizations, Dr. Harrington notes. "States need to take a close look at the consequences before they implement that kind of policy," she says. "That could increase the overall cost of care."

Contact Dr. Harrington at (415) 476-4030 or Charlene.Harrington@ucsf.edu. ■

Churning expected to worsen after the Medicaid expansion

The problem of "churning," when individuals cycle on and off Medicaid rolls, is expected to increase after the Medicaid expansion, according to a study published in the February 2011 issue of *Health Affairs*, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges."

Researchers estimated that half of all adults with incomes under 200% of the Federal Poverty Line (FPL) would experience income changes within one year that could cause a shift in eligibility between Medicaid and the insurance exchanges.

The average Medicaid beneficiary is enrolled for only three-quarters of the year, with adults retaining coverage for an even shorter period, according to a 2008 George Washington University study, Improving Medicaid's Continuity of Coverage and Quality of Care.

Churning in its current form, which means an individual goes from being on Medicaid to being uninsured, then back on Medicaid again, is costly in terms of administrative spending for states to deal with enrollment paperwork, says **Benjamin D. Sommers**, MD, PhD, lead author of the Health Affairs study and an assistant professor of health policy and economics at the Harvard School of Public Health in Boston. It is also costly to beneficiaries due to disrupted coverage, delays in care, and potentially adverse health effects, he says.

"The churning we discuss in our new research is somewhat different," says Dr. Sommers. "Under health reform, people with income fluctuations will move back and forth from Medicaid to the exchanges."

While this does result in administrative costs and potential adverse effects on continuity of care, Dr. Sommers says that low-income families will be much better off under health reform than they are now. "In 2014, if they lose Medicaid, at least they won't become uninsured," he says. "They can still get coverage through the exchange."

Income changes are extremely common for adults at or below 200% FPL, according to the *Health Affairs* study. "Each year, more than half of them will experience a month-to-month income change that is large enough to shift them from Medicaid to exchange eligibility, or vice versa," says Dr. Sommers. "This will potentially affect tens of millions of adults."

Dr. Sommers says that it's a mistake to think of the Medicaid and exchange populations as two distinct groups of people. "There are going to be millions transitioning back and forth regularly between the two programs," he says.

This sort of disruption would be very harmful for continuity of care, warns Dr. Sommers, especially for adults with chronic conditions. "The big risk is that if plans and provider networks differ between the two, people may lose benefits," he says. "They may even have to change doctors each time their income changes."

Continuous eligibility

Changing to a 12-month continuous eligibility policy is one possible approach to reduce churning, says Dr. Sommers. People would be guaranteed that they could stay in a single program throughout the year and only re-check their eligibility every 12 months, he explains.

In addition, says Dr. Sommers, states should consider incentives for health plans to participate in both the Medicaid and exchange markets, using similar benefit designs and provider networks. "This would minimize the disruptions in care that could result from churning," he explains.

Churning is a long-standing problem for Medicaid, says **Margaret A. Murray**, CEO of the Association for Community Affiliated Plans (ACAP). "We are very concerned

about the cost of churning to individuals," says Ms. Murray. "Many end up being disenrolled, despite being eligible, because of administrative problems. They come back onto the program several months later when they need care."

This causes major problems for beneficiaries who may not get prenatal care or asthma medications filled, says Ms. Murray. "They end up in the ER, and of course Medicaid pays for that," she says. "The problem has really intensified with the impending creation of the exchanges."

Not only will individuals be churning off Medicaid, but other individuals may be churning into the exchange and then out of it again, says Ms. Murray.

"We are concerned about that type of churning, too. As they move between Medicaid and the exchange, the health plans may be different, meaning the networks may be different," says Ms. Murray. "It would be fine if they just churned once, but many people will be churning multiple times."

This will result in an "enormous cost to the states and the exchanges," says Ms. Murray, for tracking eligibility, copayment levels, premiums and subsidies.

Retention increases

About half of states currently allow children to be continuously eligible for Medicaid for a year, notes Ms. Murray. Some states have also implemented Express Lane Eligibility systems, so that people can remain eligible for Medicaid when their redetermination data comes up, she adds.

"We have seen that when states make these changes, it does increase the level of retention," says Ms. Murray. "States have tended to do a lot more of this for children than they have for adults. Children, of course, are less expensive than adults."

Continuous eligibility for adults is not allowed under current law, and this should be changed, argues Ms. Murray. "The sooner the administration can clarify that states can do continuous eligibility, the better," she says.

Ms. Murray adds that the Secretary of the Department of Health and Human Services should be able to allow states to have continuous eligibility for adults through regulations. The PPACA gives her tremendous flexibility to make sure that programs operate efficiently," she says.

Ms. Murray says it's also important that the health plans that serve Medicaid clients can be in the exchange, so that people can go between two programs but keep the same health plan. "All of the safety net plans want to enter the exchange, but many are concerned about the reserve requirements," she says. A phase-in of the reserve requirements would make it easier for the plans to enter the exchange while building up the necessary reserve, Ms. Murray explains.

In the long run, says Ms. Murray, continuous coverage is much better for Medicaid beneficiaries, and it makes administering the program much easier for the state. "We'd like to see Medicaid administrators go from being gatekeepers keeping people out of the program, to being doormen ushering people into good quality health care," she says.

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Medicaid looks to payment reform to save money and improve care

States are pursuing a number of reform models for changing the way health care providers are paid, reports **Deborah Bachrach**, special counsel at Manatt, Phelps & Phillips, a health law and consulting firm in New York City, and former New York Medicaid director.

Although each state develops its own Medicaid purchasing strategies and payment policies subject to federal approval, says Ms. Bachrach, there are common themes. "All states want to advance payment and delivery strategies that will contain costs and improve quality," she says.

For many states, says Ms. Bachrach, this includes a review of fee-for-service payment methods and levels. "These policies are the building blocks of payment innovations such as medical homes and bundled and global payments," she says. "Fee-for-service policies also inform Medicaid managed care premium rates and care models."

Hospital rate decreases

States are increasingly targeting potentially preventable readmissions and complications as a way to improve quality and produce savings relatively quickly, according to Ms. Bachrach. States compare the risk-adjusted readmission or complication rates of hospitals, she explains, and reduce the payment rates of hospitals with relatively higher levels of potentially preventable events.

"Using a rate-based approach, states can both save money and create incentives for care improvement," says Ms. Bachrach. "The opportunity is significant."

The December 2010 report, *Hospital Readmissions among Medicaid Beneficiaries with Disabilities: Identifying Targets of Opportunity*, from the Hamilton, NJ-based Center for Health Care Strategies, found that the 30-day readmission rate for Medicaid beneficiaries with disability was 16.3%, and 50% of those readmitted within 30 days did not have a physician visit between discharge and readmission.

"While not all readmissions are preventable, this data strongly suggests that readmissions can be reduced with proper incentives and improved care transitions," says Ms. Bachrach.

Payments linked to outcomes

About 40 states have taken steps to enhance primary care through patient-centered medical home initiatives, says Ms. Bachrach, using a range of payment models. While some states pay primary care practices for achieving medical home certification, she notes, others pay for specific services or interventions such as care coordination.

"Consistent with the [Center for Medicare and Medicaid Innovation] priorities laid out in the ACA [Affordable Care Act], states are looking for opportunities to align their medical home initiatives with those of other purchasers," says Ms. Bachrach.

In some states, payments are risk-adjusted to reflect patient acuity, says Ms. Bachrach. "More advanced states are linking payments to outcomes, such as reduced emergency room visits and hospital admissions," she adds.

Ms. Bachrach says that "almost every state" is exploring how to maximize the potential of the health home option provided under the ACA.

"With two years of 90% federal matching dollars, states are evaluating how health home services can enhance efforts to reduce costly emergency room visits and inpatient admissions and readmissions for their chronically ill Medicaid enrollees," she says.

States recognize their increasing power in the health care market, adds Ms. Bachrach. "They are using that position to purchase cost-effective, quality care for Medicaid enrollees, and to make evidence-based decisions on what services to buy and how to buy them," she says.

By doing this, says Ms. Bachrach, they can "assure access, improve quality, and manage the costs of Medicaid beneficiaries today and the millions more expected to enroll in 2014."

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Medicaid's early payment reform efforts appear "very promising"

Many of the payment reform approaches outlined by the Center for Medicare and Medicaid Innovation (CMMI) established by The Centers for Medicare & Medicaid Services are initiatives that states have pursued for some time, such as medical homes, says **Neva Kaye**, managing director for health system performance at the Washington, DC-based National Academy for State Health Policy (NASHP).

With CMMI, not only can Medicaid programs get support for implementing payment innovations, but they can also join with multipayer efforts including Medicare, notes **Anne Gauthier**, a senior fellow at NASHP.

"That is huge, not only for serving duals but also joining with the private sector," says Ms. Gauthier. "There are states that are poised to take advantage of this. It will have the effect of propelling payment reform."

While payment reform will probably not solve budget problems immediately, Ms. Kaye says, the results of some early state efforts are "really very promising."

"It's not often a short-term solution," says Ms. Kaye. "But states and other payers are going to have to change how they pay for things, to sustain what they are doing over the long haul."

However, Ms. Gauthier notes that there are some significant savings that Medicaid programs can realize by not paying for ineffective care or "never events."

Reducing avoidable hospitalizations, says Ms. Gauthier, not only has "great promise for saving a fair amount of money, but also greatly improving the patient experience."

The Affordable Care Act includes most of the promising approaches, says Ms. Kaye, such as medical homes, improving care of dual eligibles, smoothing the transition in and out of hospitals, bundling payments, and non-payment for health care-acquired infections.

"None of these approaches are untested. All have been tried somewhere, at least on a small scale, in at least one state," says Ms. Kaye. "Already, they are starting to show some returns."

Evidence is building

There is "very clear evidence" that payment reform policies work, and have the intended effect, says Ms. Gauthier. When there is no reimbursement for "never events,"

she says, the occurrence of these events decreases.

There is also strong evidence that medical homes save costs at the state level, says Ms. Kaye, pointing to Oklahoma's program, which is now showing improved Healthcare Effectiveness Data and Information Set measures.

"The program is showing savings and the improvements are real," says Ms. Kaye. "Oklahoma is seeing the results they were hoping for. You see some of that in other states as well."

Ms. Gauthier says that the private sector is adding to the body of evidence that payment reforms work.

She gives the example of ProvenCare, a program implemented by Danville, PA-based Geisinger Health System.

"They guarantee, for a price, that if there are complications then the payer doesn't have to pay more," says Ms. Gauthier. "They are finding that the quality is going up and the costs are going down."

The CMMI is well aware of the payment reform models that have been shown to reduce costs, according to Ms. Gauthier. "I think they will be fairly generous in awarding states the opportunities for states to take on these models," she says. "I also think they will be very much geared toward anything that has a multipayer aspect to it."

Leaders and pioneers

States that pair with the private sector to put reforms in place are likely to be encouraged by CMMI, says Ms. Gauthier, along with Medicaid programs that work with the state employee purchasing program to do so.

The Medicaid expansion, says Ms. Gauthier, means that the need to reform payment is greater than ever. "As Medicaid is covering more of the population, it will have more of an impact on overall care delivery for everybody," she says. "That is a very positive thing."

There are always the leaders and pioneers that are going to try new approaches, says Ms. Kaye, and these are now becoming proven models. She points to managed care in the 1990s.

"Once it started showing savings, it spread quite far and rapidly within Medicaid," says Ms. Kaye. "When all is said and done, we are going to look back and say that these payment reforms indeed resulted in improved quality and access to care."

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