State Health Watch

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In This Issue

Are block grants the wave of the future for Medicaid?

If recent state efforts to reform Medicaid, including Rhode Island's and Texas's, prove to be successful, we are likely to see similar approaches in other states, says **Elizabeth Weeks Leonard**, JD, associate professor of law at the University of Georgia in Athens.

"States are certainly capable of coming up with innovative, successful alternatives to the current federal requirements for providing health care to low-income individuals," she says. "Block grant waivers are certainly a realistic possibility."

Ms. Leonard notes that President Obama voiced support for state waivers in a speech to the National Governors Association this spring, and also for fast-tracking the timeframe for granting waivers as provided in the Affordable Care Act (ACA), from 2014 to 2011.

"So far, the Obama administration seems quite willing to entertain state experiments with various aspects of federal health reform implementation, including Medicaid expansion," says Ms. Leonard.

Medicaid is "a political hot potato that no one seems particularly anxious to hold onto," says Ms. Leonard. "If states can figure it out, while meeting the minimum level of

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

Ohio Medicaid prepares for reform; optional services taken off table

Ohio Medicaid managed to keep optional services off the table throughout the recession, despite having a "fundamentally changed" economy in the state, according to Medicaid director **John McCarthy**.

Fiscal Fitness: How States Cope

"We are only second to Michigan in job loss," he says. "The legislature and the governor are trying to bring jobs back to Ohio, and then the Medicaid rolls will slowly go down. But it's going to take time to get that manufacturing base back up."

In May 2011, Ohio's unemployment rate was 8.6%, notes Mr. McCarthy, and the state lost approximately 400,000 jobs between 2007 and 2010.

Medicaid's optional services remained intact mainly because Ohio didn't include the extension of enhanced Federal Medical Assistance Percentages (FMAP) in its FY 2010-2011 budget, according to Mr. McCarthy. The extension of FMAP brought about $500 million in additional Medicaid funding to Ohio, he says.

It wasn't known whether FMAP

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

State Health Watch
The Newsletter on State Health Care Reform

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AHC Media

Cover story

Continued from page 1

benefits and coverage expansion that ACA envisions, I expect the administration to be very agreeable."

Matthew Mitchell, PhD, a research fellow at the Mercatus Center at George Mason University in Arlington, VA, says it helps that block granting has been embraced by people all over the ideological spectrum. "It's not just something that Republicans or conservatives or free market people are talking about," he says. "Some people think that the administration might even be willing to grant a good number of these waivers. They really don't want to set up a fight with the states over this."

However, the administration may be unwilling to give ground when it comes to additional flexibility on eligibility requirements, adds Dr. Mitchell. "That may be a big sticking point that will make administration less likely to work with states on offering block grants," he says. "A hallmark of the ACA is trying to get more people into Medicaid. That is how they will achieve their goal of getting more people covered."

Fewer strings attached

If states can receive block grants with relatively fewer federal strings attached, says Ms. Leonard, they may be able to support successful alternative models of government health care programs.

States have a mixed record of successes and failures with experimentation with Medicaid, notes Ms. Leonard, including Oregon's "rationing" plan in 1993, Tennessee's "TennCare" Medicaid managed care plan beginning in 1994, the Massachusetts comprehensive health reform plan in 2006, and Vermont's single-payer plan in 2011.

Oregon's plan to provide minimum basic health coverage to all low-income adults met with political challenges, adds Ms. Leonard, while TennCare met with financial and administrative challenges.

"But those were bold, controversial experiments, altering many basic premises of Medicaid," she says. "More modest experiments at the state level have been successful to varying degrees."

States have a long history of administering public benefits programs, adds Ms. Leonard, and their on-the-ground expertise could certainly pay off if given the chance. In fact, states may have a different, and perhaps better, sense of which people need care the most and the most efficient way to get care to those people, she says, compared to the federal government.

"Medicaid is a huge budget item in most states, and federal funding never seems adequate to fill the gaps," says Ms. Leonard. "The need for medical care by low-income individuals is enormous."

Removing the additional federal overlay of regulations may ease the administrative burden of running a successful state Medicaid program, says Ms. Leonard. "Increasingly, states are concerned that federal dollars fail to provide adequate funding, and that the federal requirements are too onerous," she says.

Federal Medicaid authorities have been fairly generous in granting waivers to all or parts of state Medicaid programs, she adds. "This notion of states as 'laboratories of democracy,' conducting policy experiments that may be adopted by other states or the federal government, has long been recognized as a value of our federal system," says Ms. Leonard.

However, Ms. Leonard notes that reimbursement levels for Medicaid providers have historically been so low compared to commercial insurance that it is extremely hard to recruit and retain enough physicians

willing to see Medicaid patients.

"Even if states figure out how to run Medicaid more efficiently than the federal government, they still face the challenge of how to incentivize doctors to see Medicaid-eligible patients," she says.

Opportunity for changes

Some Medicaid reform approaches will undoubtedly work better than others, says Dr. Mitchell. "Some states will be doing things right, and others will be doing things less right," he says. "In my view, though, even if you do things less right, that's still an opportunity to change. You are not locked into it."

There are no current demonstrations involving cost sharing for patients, or giving patients greater ability to shop around for different providers, or allowing care to be obtained across state lines, notes Dr. Mitchell.

"We don't really know what the results would be, because we have never let those experiments run," he says. "It's still probably a better bet than 'one size fits all.'"

One potential lesson for states, says Dr. Mitchell, involves Tennessee's expansion of Medicaid with its TennCare program, which was later audited by a consulting group. "They said it would bankrupt the state, so they had to dramatically draw back eligibility," he says. "Overnight, 200,000 people were dropped from the Medicaid rolls."

If a state has to suddenly cut back eligibility that was expanded, as occurred in this case, says Dr. Mitchell, "it can be more painful than if you had never expanded eligibility in the first place."

On the other hand, states are taking note of the encouraging results of the Cash & Counseling program, adds Dr. Mitchell, and are waiting to see the response to requests for waivers by states such as Utah and Washington.

Federal government's stance

Dr. Mitchell argues that the federal government's approach in taking reductions in eligibility off the table is short-sighted. "Why would you allow Arizona to stop covering transplants, but Arizona is not allowed to reduce eligibility for those recipients with relatively higher means of either wealth or income?" he asks.

Instead of denying coverage altogether, says Dr. Mitchell, transplants could have been covered on a sliding scale with higher copays for some Medicaid recipients. "That, to me, seems like a reasonable tradeoff," he says. "It seems that the federal government is only looking at one dimension, which is eligibility."

Requests that include some form of cost sharing among recipients are more in line with the approach outlined in the ACA, adds Dr. Mitchell. "If you can get recipients to share even a little bit, even if it's a $10 copay, that encourages them to shop around," he says. "It introduces some measure of price sensitivity and competition."

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Fiscal Fitness

Continued from page 1

would be extended when Ohio's last budget was passed two years ago, he explains, so it wasn't included. "When the FMAP was extended, that freed up more money in the Medicaid program," says Mr. McCarthy. "Hospitals were supposed to take a rate cut, but ended up not having to because of those extra dollars."

When FMAP was extended, hospitals were given $150 million in the form of a provider fee decrease, adds Mr. McCarthy.

Cuts to optional services are still not on the table, according to Mr. McCarthy, mainly because they result only in short-term savings. For example, cutting dental care increases the number of people who visit the emergency department with untreated dental problems, he says.

"In the first year, there is no way that those costs would get all the way up to the cost of the optional services that were cut," he says. "But when you get to the second or third year, you start seeing increases in costs."

Back to beginning

Due to the transition with a new administration, the planning process for the Medicaid expansion in 2014 "went all the way back to the beginning," says Mr. McCarthy. "We have reviewed all items, to be sure that any decisions that had been made go along with this administration's priorities."

For instance, he says, the state had to take a new look at the question of whether it would run the exchange or allow the federal government to run it. "The decision was made to move forward with planning the exchange," says Mr. McCarthy.

Some requests for proposals were recently released, says Mr. McCarthy, and the agency is moving forward with the assumption that health care reform legislation will not be overturned.

"It is difficult at times. We need to stop and make sure we are not doing anything that is going in a completely wrong direction from where the state is moving overall," he says. "At the same time, we want to be sure that no matter what happens, we're not behind."

Very tight budget

The biggest challenge for Medicaid at this juncture is an extremely tight state budget, says Mr. McCarthy.

"Trying to navigate through that is quite difficult. You are limited in what you can do in the Medicaid program," he says. "There have been a lot of ideas floated our way. Some of them you can do, and some of them you can't do."

One suggestion that fell into the latter category was to increase revenues with higher copays and deductibles, says Mr. McCarthy. "We do not have that expansive of a program here. Once you take moms, kids and pregnant women off the table, that's over half of our program. When you take out the ABD [Aged/Blind/Disabled] population, it's another quarter or so," he says. "There's not enough people left for a dollar impact."

Increases in copays and deductibles would end up having more of a negative impact on Medicaid providers, he says.

The loss of enhanced FMAP will mean an $800 million loss for the state's two-year fiscal year 2012-2013 budget. "We tried to fill that hole with policy changes first. After that, we did have to look at provider rate reductions," says Mr. McCarthy. "We did not touch optional services."

Nursing homes will take a 5.8% reduction, and hospitals about 2%, says Mr. McCarthy, and managed care organizations will take a 1% reduction in administrative fees. "The total Medicaid budget achieves an unprecedented level of Medicaid savings — $1.4 billion over the biennium," he reports.

The two-year budget poses an additional challenge, says Mr. McCarthy, since it's difficult to project what revenues and enrollment will look like in 2013. "We are seeing increases in enrollment, but not at the 4% rate of growth that we were seeing a little while ago," he says. The budget assumes enrollment growth will slow to about 2.6% in 2012, and down to 2% the following year, he says.

"After past recessions, we have seen a decline in the number of people in the program. This time, we are not seeing that," adds Mr. McCarthy. "We are just seeing a leveling out in the level of growth. We continue to see utilization go up."

New eligibility system

Ohio is moving forward in trying to obtain 90/10 funding for a new Medicaid eligibility system, reports Mr. McCarthy. "We have a very old eligibility system here, created before the de-linking of Medicaid from TANF [Temporary Assistance for Needy Families], that lacks online capability," he says.

One goal is to simplify the eligibility process, says Mr. McCarthy, as the current 30-year-old system requires a

Better management of duals is Ohio Medicaid's survival plan

Ohio Medicaid got by with policy changes and rate reductions for the past two years, says Medicaid director **John McCarthy**, but future efforts are going to focus on better management of high-cost clients, including dual eligibles.

"We are struggling with where our savings are going to come from in the future," says Mr. McCarthy. "Two years from now, we are really banking on the fact that better care coordination and less fragmented services are ultimately going to lead to savings."

About 4% of the Medicaid population accounts for 51% of the program's expenditures, he adds. While some in this group are costly because they live in an institution, explains Mr. McCarthy, others are high-cost because of unnecessary ED visits, diagnostic tests and hospitalizations.

The budget includes $47 million to implement medical homes and accountable care organizations late in 2012, with the hope of achieving savings in the Medicaid program sometime in 2014, says Mr. McCarthy.

"We are developing health homes, and will hopefully get some of them up this year, but the bulk of them will probably be implemented next year," he says. "We are putting those in place to address Medicaid savings further out."

Enrollment is not capped in the Passport Medicaid waiver program, which provides home and community-based services as an alternative to nursing homes for Ohio residents 60 and older, says Mr. McCarthy. "We do have that as a lower-cost alternative to nursing home services. We've been making great strides with that," he says.

Controlling costs of dual eligibles, though, is going to be a major focus going forward, says Mr. McCarthy. "We are trying to come up with a single point of care coordination between Medicaid and Medicare, to ultimately lead to savings in the future," he says. "The problem is, not only do you have Medicaid and Medicare, but within our program you have various other pieces."

For instance, he says, the waiver program doesn't offer care coordination that is included in other programs. The goal is to take all services and put them under a single entity, Mr. McCarthy explains, whether managed care, accountable care organizations, or health homes.

"We are open to all different forms of delivery," says Mr. McCarthy. "But we need something that can better coordinate the care across those programs, ultimately leading to lower costs." ■

number of determinations to be made manually. "To fix these things would take millions of dollars," he says. "Instead of investing in that, we're investing in a new eligibility system."

There are still some pieces of the eligibility system that link Medicaid and TANF, says Mr. McCarthy, which require manual processes to get around. "The system was fixed partway with a workaround. But as time goes by, we need something that is more simplistic," he says.

Mr. McCarthy says he's waiting for guidance from the Centers for Medicare & Medicaid Services regarding the performance measurement that is required around eligibility determinations. "That's a concern to us. How do you design a system when you don't know what the performance standard is going to be?" he asks. "That's a bit frustrating. Obviously if I had that now, it would make my planning a lot easier."

Meanwhile, says Mr. McCarthy, the agency is trying to answer such questions as what constitutes a family unit, how often taxable income needs to be checked, and whether wage changes have to be changed instantaneously for Medicaid.

"There are a lot of outstanding pieces there on the Medicaid side, which rolls over onto the exchange side, such as the ability to determine what the tax credit should be for people," Mr. McCarthy says. "That is another issue we are going to have to deal with."

Contact Mr. McCarthy at (614) 752-3739. ■

Some argue Medicaid can't meet obligations without fundamental reform

Many of the current fiscal challenges faced by states appear similar at first glance, says **Matt Salo**, executive director of the National Association of Medicaid Directors in Washington, DC, but they are never truly the same. "States are all in very different positions," he says. "The block grant issue is an interesting one."

Block grants involve changing both the financing of the Medicaid program and the rules by which states must live while administering it, notes Mr. Salo. "On some level, it is a political discussion," he says. "The phrase 'block grant' is sometimes used, or avoided, based entirely on the political party of those talking."

However, block grants are part of a broader political discussion that involves federal spending and entitlement programs and includes Medicare as well, notes Mr. Salo.

"Medicaid is currently an unlimited matching program where for every dollar a state spends, the feds will spend a commensurate dollar—or two or three, depending on the FMAP [Federal Medical Assistance Percentages], " he says.

While some people want to cap this exposure to the federal government for fear that states are "gaming the system," says Mr. Salo, others simply want to limit the federal exposure, period. "In fact, some states are considering trying to cap their own exposure," he says. "It all boils down to Medicaid program expenditures rising faster than the capacity of revenues to keep up."

Current financing structure

While all states would argue that they need more flexibility in administering the Medicaid program, says Mr. Salo, not all would agree that accepting less money is an appropriate tradeoff for that.

"However, I think that every state would argue for rethinking and improving the way the program is run," says Mr. Salo. "Not all will call it 'block grants.' But many states are very concerned that without fundamental reform, the program's obligations and expectations simply cannot be met with its current financing structure."

At the end of the day, there may not be much difference between "requesting a block grant" and "requesting an 1115 waiver," says Mr. Salo, except that the first, in theory, might provide states with more guarantees that they can do what they wanted. In contrast, he explains, the federal government can deny a waiver request or tie it up in red tape.

"A true 'block grant' is a pipe dream. It doesn't and won't exist," says Mr. Salo. "At no point would Congress ever agree to simply hand over hundreds of billions of dollars to states with no strings attached."

Current discussions revolve around what changes to financing are feasible, says Mr. Salo, and "what of the thousands and thousands of pages of rules, regulations and guidance could be gotten rid of."

There is no question that states could operate their Medicaid programs more efficiently without any federal regulation, according to Mr. Salo. "For argument's sake, they could probably cover more people, too, although expanding government coverage of health care is not necessarily on every state's political agenda," he says.

Mr. Salo says that an old Medicaid joke is that, given the dynamics between financing and program operation, the right would gladly give the states as much flexibility as they want, but less money

and the left would give states as much money as they want, but less flexibility. "And so, we stay with the status quo," he says.

Contact Mr. Salo at (202) 403-8621 or matt.salo@namd-us.org. ■

Medicaid clients may pay higher copays for inappropriate ED use

While many cost-cutting measures being proposed by states to save money in their Medicaid programs require a waiver, this is not necessarily the case with emergency department copays as states already have some flexibility to do this, notes **Joan Alker**, co-executive director at the Georgetown Center for Children and Families and a research associate professor at Georgetown University's Health Policy Institute.

"A number of states have proposed higher copays for inappropriate use of the ER," says Ms. Alker, adding that charging a copay is not necessarily the right solution for the problem of inappropriate use of the ED.

There must be other providers who are accessible and convenient, patient education about ED use, and available help lines for patients to contact to cut down on inappropriate use, says Ms. Alker. "The copays need to be combined with these other approaches, I think, to be successful," she says. "States need a more comprehensive policy approach."

Peter Cunningham, PhD, a senior fellow and director of quantitative research at the Center for Studying Health System Change in Washington, DC, points to Florida's Medicaid reform initiative, which includes a $100 charge for a non-urgent ED visit.

"I think there are a lot of potential issues with that," he says. "$100 is not going to be affordable for the vast majority of people on Medicaid. And the main problem is, how do you define a non-urgent visit?"

If a possible life-threatening emergency turns out to be something minor, says Dr. Cunningham, hospitals will "just game the system. They will be aware of this and will be creative in how they code the reason for the visit."

Copays, says Dr. Cunningham, are a "pretty blunt instrument to use to try to get Medicaid enrollees out of the ER."

While it's true that Medicaid enrollees do have very high rates of ED use, says Dr. Cunningham, access to care and defining a non-urgent visit must both be considered. "Are there other places for them to go in the community?" he asks. "A lot of providers won't take Medicaid patients because of low reimbursement."

Medicaid programs aren't likely to save much money or reduce ED use significantly by adding copays, according to Dr. Cunningham, "but to the extent they do, it will probably result in problems with access to care."

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Alabama Medicaid targets ED overuse, but not with copays

Alabama Medicaid hasn't made any changes to its copays, which are $3 for outpatient hospital visits and exempted for emergencies, nursing home patients, pregnant women, children or patients receiving family planning services, and doesn't intend to do so, according to the state's Medicaid medical director, **Robert Moon, MD**.

Alabama's Medicaid program is taking steps to address ED overuse, however, by monitoring clients with a high number of ED visits, says Dr. Moon.

If a recipient has been to the ED five or more times in the past quarter, he explains, they're referred to the state public health department for care coordination. Currently, Alabama Medicaid is starting up pilot care networks in three regions with an enhanced case management component, reports Dr. Moon, and individuals overusing the ED will be prime candidates for this service.

"Our eligibility levels are so low, particularly for adults, that copays have not been our focus. Basically, you are taking money out of the hospital's pocket," says Dr. Moon. "Our focus has been care management, via the health department interventions."

Although the health department's care managers will continue to be utilized, says Dr. Moon, the networks will provide additional care management. "Part of what they are charged with is assessing high utilizers," he says. "Decreasing the number of ER visits and readmissions is going to be our major focus."

The care networks, which were approved by the Centers for Medicare & Medicaid Services in May 2011, are modeled after Community Care of

North Carolina's, says Dr. Moon, and started delivering services in August 2011.

"In North Carolina, where they have similar networks that have been in existence for several years, their ER utilization has decreased," notes Dr. Moon.

Better continuity of care

Between the case managers newly hired by the networks and the health department's case managers, which have been in place for several years, says Dr. Moon, the expectation is that high ED utilizers will get much better continuity of care. The hope, he says, is that they will use their primary care physicians for needed care and avoid the emergency department for non-emergent conditions.

Of the 80,000 Medicaid clients in the three regions, two patients had been to the ED 53 times in a single year, says Dr. Moon. "Obviously, there is either an unaddressed medical problem or just a pattern of utilizing the ER for lots of things, that needs to be addressed," he says. "Even if we could get 53 visits a year down to 25, I would consider that a win."

Most Medicaid recipients are assigned a medical home and either choose a primary care physician or are assigned one, says Dr. Moon. "Access is certainly available to them. Part of it is them just learning to use it," he says. "Some of these folks might not even be aware they have a primary care physician."

Providers and the networks are being encouraged to contact patients who have never been seen at the practice, says Dr. Moon, and to contact previous patients who have been high ED utilizers to encourage more frequent office visits.

To help align incentives, a shared savings program rewards primary care doctors for appropriate ED utilization by their patients, says Dr. Moon. "We also pay them a case management fee for each member, to help reward the work done in facilitating that each patient gets the right care in the right setting," he adds.

Data such as the average number of ED visits per patient per year will be analyzed, says Dr. Moon, as well as data on outliers. While the five visits per quarter is a flag for individuals to be contacted by case managers in the public health system, the regional networks will be reaching out to anyone they think is overusing the ED, he explains.

"We hope to address the issue even more aggressively than that," says Dr. Moon. "If the networks think five times a year is too much, they're going to be targeting those patients for interventions. We want better continuity of care for patients, and you're not going to get that in the ER."

Contact Dr. Moon at (334) 242-5619 or robert.moon@medicaid.alabama.gov. ■

Medicaid's mandatory mental health screenings ID 14,000 at-risk children

Massachusetts' new court-ordered mental health screening and intervention program led to 220,000 more children being given screenings, and 14,000 more children being identified as behaviorally and emotionally at risk, according to a recent study[1].

Researchers from MassGeneral Hospital for Children in Boston looked at Medicaid well child visits from 2008 and 2009 that included behavioral health screens mandated by the Children's Behavioral Health Initiative (CBHI). The researchers demonstrated a significant increase in referrals for mental health evaluations for children with Medicaid during the same time period.

In 2006, Massachusetts lost a class action lawsuit brought by advocates arguing that the state lacked comprehensive and well-organized services for the mental health needs of children, notes **Michael Jellinek**, MD, chief of child psychiatry at Massachusetts General Hospital. The judge ordered that the Medicaid program provide a full spectrum of services for children beginning in July 2009, including behavioral health screening, he explains.

"The deeper reason this is important is probably over 10% of children have substantial emotional problems," says Dr. Jellinek. While pediatricians recognize some of these problems, many go unrecognized or are recognized only after the problem has already gotten more serious, he says.

For instance, a depressed adolescent could receive therapy and/or medication before he or she suffers years of negative effects, says Dr. Jellinek, or a younger child with attention deficit disorder could be treated before having problems in school.

Children are now screened for various mental health issues depending on their age, such as autism in the first couple years of life and substance abuse in adolescence, he says, and all children ages four to 16 are screened using a one-page pediatric symptom checklist.

Dr. Jellinek, who developed the checklist, says that its purpose is to alert the pediatrician that the child or adolescent is not functioning well, either with friends, in school, or in the family, and that there is a problem in this area that needs further exploration.

"Pediatricians are identifying children they didn't know about," he says. "The first step is to find them."

Tests not widely used

After mandatory screening was implemented, says Dr. Jellinek, the percentage of children on Medicaid who were screened went from just a few percent to almost half. "The study demonstrates that although everybody knew these kids had problems, until there was training and a court order and some reimbursement, these tests were not very widely used," he says.

To date, 24,000 children have been identified as being at risk, says Dr. Jellinek, and would likely not have been identified prior to implementing mandatory screening. Some of these patients may be treated by pediatricians, some may be sent for mental health evaluations, and some don't follow through, he says.

"It's still not perfect. Not all kids that screen positive get sufficient attention," he says. "We're not there yet, but it's better than when we weren't screening anyone."

Available providers would have been overwhelmed if all of the children who screened positive were referred, says Dr. Jellinek, but in fact, not all seek treatment. "We need to beef up the options that parents have, but alerting parents that there is a problem is an important first step," he says.

Contact Dr. Jellinek at (617) 726-2711 or mjellinek@partners.org.

REFERENCE

1.Kuhlthau K, Jellinek M, White G, et al. Increases in behavioral health screening in pediatric care for Massachusetts Medicaid patients. *Arch Pediatr Adolesc Med* 2011; 165(7):660-664. ■

Many physicians report barriers to benefits of e-prescribing

The benefits of e-prescribing to patient care are often touted, but the reality is that physician practices often find some features cumbersome and unreliable, according to a new study from the Center for Studying Health System Change (HSC) in Washington, DC[1].

Researchers looked at 24 physician practices using e-prescribing systems, focusing on the use of features that allow access to external patient-related information that could improve prescribing decisions.

"Adoption of e-prescribing and specific e-prescribing features has generally been low among physicians," says **Joy M. Grossman**, PhD, lead author of the study and a senior researcher at HSC.

While physicians have been able to use their computers to generate prescriptions for some time, says Dr. Grossman, they can't always access information from outside sources to help them at the point of prescribing. "We decided to look at this more closely," she says.

Even if physicians are using e-prescribing systems to send prescriptions, not all of them have access to the patient's medication history or the formulary, says Dr. Grossman. "In some cases, the systems didn't offer it," she says. "In other cases, they didn't implement it."

While most of the 24 practices reported that physicians had access to formulary information, only about half reported that physicians had access to patient medication histories, according to the study.

Researchers found that among practices with access to the information, the tools to view and import data into patient systems were sometimes cumbersome to use, and data weren't always seen as useful enough for physicians to spend extra time reviewing it.

Even when physicians do use e-prescribing, says Dr. Grossman, they often don't use all the available features because they're unaware of them, or because they're too difficult to use.

"With more interest in e-prescribing because of the federal incentives, this is particularly timely," adds Dr. Grossman. The "meaningful use" requirements for electronic health record use by providers to qualify for incentives are focused on using the system to send prescriptions electronically, she explains.

While the requirements around use of third party data are less stringent during the first stage of the program, adds Dr. Grossman, they may increase over the three stages of the program.

Even when physicians have access to the features, data weren't always available for a given patient, adds Dr. Grossman, and in some cases physicians considered the data to be outdated, inaccurate, or of limited use. "Often, it was hard for physicians to access that information," she says. "It wasn't readily apparent, and they had to take extra steps to get it."

Physicians weren't always able to act on what they learned, says Dr. Grossman, such as changing the originally prescribed medication to one on the formulary, or importing a medication prescribed by another physician into a patient's medication list.

"Some systems are designed to work with a click or two. If the system was more cumbersome, physicians tended to use the feature less," says Dr. Grossman. "Some feel it's easier to have the pharmacy deal with formulary information."

Potential for cost savings

"Physicians can use the patient's medication history information to reconcile their existing medication list," says Dr. Grossman. Without third-party information coming from

adjudicated claims data from participating health insurers and pharmacy benefit managers, she explains, the only information physicians have is what they and their colleagues prescribed, and what the patient tells them.

Formularies also come from participating health insurers and pharmacy benefit managers, adds Dr. Grossman. "Most systems also provide access to information on generic alternatives from third-party medication databases," she says. "Without knowing anything about the patient's insurance information, the physician could pull up less costly alternatives."

Together, all of these things potentially can improve the quality of the prescription decision-making, according to Dr. Grossman. "They can make it more efficient both on the physician practice and the pharmacy end," she says. "This potentially saves the patient money in out-of-pocket costs."

If Medicaid providers are able to access medication formularies and generic alternatives, adds Dr. Grossman, this can save the state money as well.

The more complete the data is, says Dr. Grossman, the more likely physicians are to make use of it. If a particular medication isn't on the formulary, she explains, that information isn't of much use unless the physician is given an alternative.

"It's challenging for doctors to spend time pursing additional information," Dr. Grossman concludes. "The benefit has to be greater than the cost."

Contact Dr. Grossman at (202) 484-3298 or jgrossman@hschange.org.

REFERENCE

1. Grossman, JM, Boukus ER, Cross D, et al. Even when physicians adopt e-prescribing, use of advanced features lags. HSC Research Brief No. 20, Center for Studying Health System Change, Washington D.C. (May 2011). ■

Medicaid providers face barriers to "meaningful use"

The Agency for Healthcare Research and Quality will spend nearly $425,000 over two years on a study to identify barriers to Medicaid providers meeting electronic health records (EHR) "meaningful use" criteria. Focus groups of eligible Medicaid providers will be established, including providers that have adopted an EHR, providers that have not adopted an EHR, and a dental focus group.

AHRQ has a history of engaging state Medicaid programs in a variety of ways, according to **Erin N. Grace**, MHA, senior manager of Health IT at AHRQ. "AHRQ recognizes the potential positive impact of health IT and HIE [Health Information Exchange] to improve quality of care for Medicaid and its beneficiaries, and the unique barriers and challenges for Medicaid agencies to engage in health IT and HIE," says Ms. Grace.

In 2007, AHRQ issued a contract to provide technical assistance for health IT and HIE in Medicaid and the Children's Health Insurance Program (CHIP). "Since that time, AHRQ has worked closely with CMS [the Centers for Medicare & Medicaid Services] and other federal and national partners to deliver a variety of technical assistance for Medicaid and CHIP [Children's Health Insurance Program] agencies trying to engage in health IT and HIE efforts," says Ms. Grace.

With the passage of the American Recovery and Reinvestment Act and the Health Information Technology for Economic and Clinical Health Act, the health IT landscape has changed dramatically, says Ms. Grace. "These changes have had a particularly significant impact on Medicaid agencies, and ultimately, on Medicaid providers," she says.

While there are potential barriers to adoption and meaningful use of health IT for all providers, AHRQ and CMS were interested to know if there are additional barriers that might be unique to Medicaid providers, says Ms. Grace.

"Therefore, with input from CMS, AHRQ has funded the study of these potential barriers to help inform future stages of meaningful use," she says. Medicaid directors are currently overseeing the ongoing operations of EHR incentive programs, adds Ms. Grace, and are working to help their providers meet the meaningful use criteria.

"Information from this study can help them better plan their programs to address specific barriers that the Medicaid agency might be able to address," she says. "Medicaid directors will be able to target interventions to the specific needs of their providers."

Contact Ms. Grace at (301) 427-1580 or erin.grace@ahrq.hhs.gov. ■

New round of Medicaid cuts coming, due to loss of enhanced FMAP

Illinois Medicaid anticipates a $1.2 billion loss to general revenue funds and related funds in the coming fiscal year, due to the loss of enhanced Federal Medical Assistance Percentages (FMAP), according to the state's Medicaid administrator, **Theresa Eagleson**.

"While the fiscal year 2012 budget is not yet resolved, this loss has caused the state to debate significant provider rate cuts and reductions in

Medicaid and other health care and social service programs," says Ms. Eagleson.

For example, says Ms. Eagleson, the governor's budget proposed a 6% rate cut to most Medicaid providers, as well as significant reductions to programs such as Illinois Cares Rx and other non-Medicaid health care programs, in order to make up the difference.

The enhanced FMAP provided a savings of $254 million to Alaska's general funds, says **William Streur**, commissioner of the Alaska Department of Health and Social Services (DHSS).

"With the loss of that enhancement, a gap exists in the budget that must now be filled by other means," says **Kimberli Poppe-Smart**, DHSS' deputy director for Medicaid and Health Care Policy. "We are looking at cost savings and cost avoidance measures to fill that gap."

Rather than look at cutting services, reimbursement rates or eligibility at this point, the first effort will be to identify efficiencies and quality enhancements that will result in savings, says Ms. Poppe-Smart.

"Ultimately, we anticipate there will need to be an increased spending of state general fund dollars to cover much of the gap," she says. "As a result, those dollars will not be available for other programs."

Cuts to optional benefits or provider rates may be necessary in the future, says Ms. Poppe-Smart, but at this point they are not the focus of short-term efforts.

Some possible options are enhanced use of generic medications and related pharmacy strategies, a psychiatric medication policy for certain groups covered under the Medicaid program, and a redesigned personal care attendant program, says Mr. Streur.

"The department is exploring the selection of pilot sites for patient-centered medical homes, and a chronic care management program for high utilizers," he adds.

Contact Ms. Eagleson at (217) 782-2570, Ms. Poppe-Smart at (907) 269-7827 or Kimberli.poppe-smart@alaska.gov, and Mr. Streur at william.streur@alaska.gov or (907) 334-2520. ■

For states with family planning waivers, many dollars at stake

Family planning waivers have allowed Medicaid programs in 28 states to benefit from the 90% federal matching rate for people who would not otherwise be eligible for those services, notes **E. Kathleen Adams**, PhD, professor of health policy and management at Emory School of Public Health in Atlanta.

"With these expansions, the percentage of publicly funded family planning services that are Medicaid-financed has really been growing," she says. This means that defunding Planned Parenthood, as a growing number of states are attempting to do, has significant fiscal implications for states with family planning waivers, says Dr. Adams.

In many states, Planned Parenthood is the Title X provider involved in these waivers, which have a separate source of federal funding for family planning, adds Dr. Adams. "If you are restricting the set of providers to which women eligible for Medicaid can go to, you really are putting at risk their access to, and the volume of, family planning services which will be matched at 90%," she says.

A lot of dollars are at stake for the 28 states with family planning waivers, says Dr. Adams, making it unlikely they will defund Planned Parenthood. "States with large waiver programs wouldn't think of such a thing because they have a large amount of federal funding and program participants," she says. "States are very convinced that there are plenty of dollars saved, due to reductions in unintended pregnancies and better outcomes."

When Medicaid family planning waivers are used, adds Dr. Adams, the state's total amount of family planning services grows significantly. "That's what you want. You want it to grow and your Title X dollars not to shrink, so you have actually expanded access to family planning services for low-income women," she says.

Indiana, North Carolina, Wisconsin, and Kansas defunded Planned Parenthood in their 2011 legislative sessions because some of the organization's clinics provide abortions, notes Dr. Adams, but she doesn't believe these actions will hold up in court.

Dr. Adams notes there was some debate, as the health care reform legislation evolved, over whether family planning should be considered a preventive care service provided with no copay.

After a July 2011 report from the Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps, recommended that birth control and contraceptive counseling be fully covered by health plans, the Obama administration is requiring that health insurance plans cover birth control as preventive care for women, with no copays, effective as of January 1, 2013. "There is no question that this issue is treated as a political football," says Dr. Adams. ■

Special status under Medicaid

Family planning services have a special status under Medicaid, notes **Judith Solomon**, co-director of Health Policy at the Center on Budget and Policy Priorities in Washington, DC.

"First, the federal government pays 90% of the cost, regardless of the state's regular matching rate," she says. Second, the Medicaid statute includes a provision stating that beneficiaries are free to choose among qualified providers of family planning services who are participating in the program, Ms. Solomon adds.

"While the 'free choice' provision can be waived for state managed care programs that restrict beneficiaries to a specified network of providers, there is an exception for family planning services," she says.

Even under a managed care waiver, beneficiaries must have the ability to choose any qualified provider of family planning services willing to serve Medicaid beneficiaries, explains Ms. Solomon.

"Excluding family planning providers based solely on the fact they provide abortion services, which are not covered under Medicaid except in very restricted circumstances, is in direct conflict with the guarantee of freedom of choice of family planning providers," Ms. Solomon says.

Contact Dr. Adams at (404) 727-9370 or eadam01@emory.edu and Ms. Solomon at (202) 408-1080 or solomon@cbpp.org. ■

Oklahoma medical home program exceeds goal of budget neutrality

Sixty percent of the 900,000 Oklahomans who were provided healthcare in fiscal year 2010 by the Oklahoma Health Care Authority received care from the SoonerCare Choice program, which transitioned to a Patient Centered Medical Home (PCMH) model in January 2009.

Becky Pasternik-Ikard, RN, chief operating officer of the Okahoma Health Care Authority, says that the program has resulted in almost 100% elimination of same day/next day medical access issues. "We have also seen a reduction in the calls to the after-hours patient advice line," she says.

Participants no longer have to wait 15 days when switching to a new primary care physician (PCP), she adds, and are able to see another PCP-level provider without switching from their current PCP.

"In addition, the elimination of the auto-assignment methodology has been applauded by our provider community," says Ms. Pasternik-Ikard. "Enrollment into SoonerCare Choice entails the affirmative selection of a PCP medical home."

The PCMH fosters a team approach to healthcare delivery, says Ms. Pasternik-Ikard, by engaging the patient, family, and medical staff. A care coordination fee is based on a tiered PCP classification system with a fee-for-service and incentive payment structure, she explains, all within the same budget parameters as the previous model.

The transition from the former SoonerCare Choice Primary Care Case Management Program, which operated statewide during 2004 to 2009, resulted in the reduction in the per capita expenditure for primary and preventive care services from $24.59 in 2008 to $22.53 for 2010, reports Ms. Pasternik-Ikard. "This exceeded our goal of budget neutrality," she says.

The PCMH program is viewed as the first layer in a platform to improve care to enrollees, according to Ms. Pasternik-Ikard. "We are now exploring the potential of medical homes to expand to health homes and the improved integration of physical and behavioral health," she says.

Contact Ms. Pasternik-Ikard at (405) 522-7208 or Becky.Pasternik-Ikard@okhca.org. ■

Impact of early retirees eligible for Medicaid could be small

Several million middle class people making up to $64,000 will potentially be eligible for Medicaid in 2014, according to the Affordable Care Act (ACA). For over 20 years, tax law has generally excluded a portion of Social Security benefits from income for federal tax purposes, notes **Chris Stenrud**, deputy assistant secretary for public affairs at the U.S. Department of Health & Human Services (HHS).

This exclusion phases down for higher-income taxpayers, has been reduced in scope over time, and benefits recipients of Social Security disability and survivor benefits, as well as retirees, says Mr. Stenrud. "The income definition used in the health care law to determine Medicaid eligibility and to compute tax credits continues this exclusion," he says.

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Social Security income when determining Medicaid eligibility results in more people appearing eligible for Medicaid, adds Mr. Stenrud, the number of people actually expected to enroll in Medicaid is far lower.

"HHS estimates that more than 70% of people affected by this policy are already enrolled in employer-sponsored private insurance or Medicare," says Mr. Stenrud, adding that these individuals enrolled in Medicare are not eligible for Medicaid under the ACA expansion of Medicaid coverage to low-income adults.

HHS estimates that only a small percentage of people with Social Security income would enroll in Medicaid, according to Mr. Stenrud. Most are people who have retired before age 65 and decided to receive reduced Social Security payments, he explains, and others include people with disabilities who are not yet eligible for Medicare because of the two-year waiting period and children whose parents are deceased or disabled, as well as widows and widowers.

Mr. Stenrud says that HHS has worked with states to keep Medicaid costs down and sustain coverage in the program as the economy is recovering. "However, we are concerned about state budgets," he says. "We are exploring options to address this issue, so that we can use taxpayer dollars responsibly while ensuring that all Americans have access to affordable, high-quality health insurance coverage."

Enrollment not compulsory

The issue is the treatment of Social Security benefits under the income calculation methodology, says George Washington University law professor **Sara Rosenbaum**, JD.

"Potentially, the number of persons who qualify for Medicaid once the new income methodology is applied to their Social Security payments may be large, " says Ms. Rosenbaum. "But I question how many of them ever would turn into Medicaid beneficiaries."

First, an individual would have to have income below 133% of FPL to qualify, says Ms. Rosenbaum. "There obviously may be some people who would qualify on a spend down basis, if their Social Security benefits are exempt, but the 133% rule does not apply to spend down applicants, and is not applicable to Medicare beneficiaries. That is one limiting factor," she says.

It's possible that if an individual with a disability is receiving Social Security and doesn't have Medicare yet, he or she could be eligible for Medicaid once Social Security payments are disregarded, whereas without the disregard the applicant's income would be over the 133% FPL, says Ms. Rosenbaum.

"The question is, how many of them would apply for Medicaid? The number may seem large, but when you think about how it would translate into actual enrollment in the program, my guess, for a number of reasons, is that the number is very small," says Ms. Rosenbaum.

Another issue is that it's not a compulsory enrollment requirement, notes Ms. Rosenbaum, and the number of low-income Medicare beneficiaries who are able to get social security benefits who enroll in Medicaid is low.

"This is an aspect of the law that people hadn't really focused on until now," says Ms. Rosenbaum. "But once you look at the limitations of who the new MAGI [Modified Adjusted Gross Income] methodology applies to, and the voluntary nature of the program, the actual effect of this may be pretty small."

Contact Ms. Rosenbaum at (202) 994-4230 or Sara.Rosenbaum@gwumc.edu. ■