State Health Watch

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In This Issue

After the midterm elections, Congress faces the uninsured and high costs

Significant changes in Congress, statehouses, and state legislatures from the November 2006 midterm elections may lead to a renewed interest in health care reform and new research from the Center for Health Care Strategies (CHCS) points to innovation that can be pursued in Medicaid managed care.

Commonwealth Fund President **Karen Davis** suggests the election results will bring health policy issues to the legislative front burner in 2007.

"Many candidates from both parties made health care a highlight of their campaigns and their subsequent acceptance speeches," she says. "They knew their constituents were interested. A recent Commonwealth Fund survey showed that three-quarters of all adults believe the U.S. health care system needs either fundamental change or complete rebuilding."

Ms. Davis says if the new Congress is willing to take a truly bipartisan approach to health care, the country could begin to attack the twin problems of increasing numbers of uninsured and higher health care costs. She says Democrats in key positions are likely to prioritize better coverage

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Giving an allowance for health care: In three states, patients get more say in their care

Robert Wood Johnson Foundation-funded "cash and counseling" programs in three states have demonstrated it's possible to save money and increase patients' satisfaction with the care they receive by encouraging and helping patients to manage their own care.

Fiscal Fitness: How States Cope

An evaluation by Mathematica researchers of the Cash and Counseling Demonstration for adults in Arkansas, New Jersey, and Florida looked at how a new service delivery model of consumer direction affected Medicaid and Medicare service use and costs.

The evaluators said the traditional method of providing Medicaid personal care services through home care agencies gives consumers few choices about how and when their care is provided. Thus, some consumers may not receive the type of care they believe the need, when and how they want it. And this can lead to dissatisfaction with their care, unmet needs, and discontent over the quality of life.

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State Health Watch
The Newsletter on State Health Care Reform

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Election

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for children and working families and to lower prescription drug prices. They may find common ground with some Republicans, particularly from those representing states along the border with Canada. She says there is already some innovation occurring across states to address the needs of the middle- and lower-income adults and their families who find they can't afford to get sick, even when insured, due to rising out-of-pocket costs.

Possible starting points, according to Ms. Davis, include the pending reauthorization of the SCHIP program, Massachusetts' health insurance "connector" to help small businesses and the self-employed, Medicare drug price negotiations, legislation to increase adoption of health care information technology, and a Medicare pay-for-performance system.

Changes in states, too

"The landscape has changed in statehouses as well, and new governors may make their marks on local efforts to improve quality of care and coverage," Ms. Davis wrote in a post-election analysis. "State-specific efforts, such as those already under way in Maine, Massachusetts, Rhode Island, and Vermont, could be facilitated by bipartisan federal legislation to provide federal funds to cover the uninsured, create health information exchanges, invest in primary care, and improve quality."

She says that continuing on our current course is unacceptable and more progress is needed to follow the first steps toward significant federal and state support for a high-performing health system.

"The U.S. can learn from innovative examples — both within our borders and abroad — of effective policies and practices that lead to better health for everyone," she concluded. "If Democrats and Republicans are willing to commit to working together to achieve such reform, all Americans will benefit."

Highlighting efforts in several states to improve and expand Medicaid managed care, building on its years of success, is the focus of the new CHCS report, "Seeking Higher Value in Medicaid: A National Scan of State Purchasers," which was released in time to be of great interest to newly elected governors and state legislators, according to CHCS president **Stephen Somers.**

Mr. Somers tells *State Health Watch* CHCS has been encouraging states to look for long-term benefits in Medicaid reform rather than the short-term gains that might come through cuts in provider payments or restrictions on eligibility or benefits.

Mr. Somers and his colleagues went to Medicaid directors and staff in 14 states — California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin — for a nationwide scan of the current state of Medicaid managed care. He tells *SHW* that while we often hear about budget concerns and cutbacks in various states, he was not surprised to hear the positive stories of expansion and innovation that came from the 14 states.

"We work with these states regularly and know what's happening there," Mr. Somers explains. "And the states were not chosen randomly. We deliberately looked for bellwether states. Also, our interviews were with Medicaid directors, who may have a different perspective than legislators."

According to Mr. Somers' report,

interviews in the 14 states yielded three cross-cutting themes:

1. States are generally happy with and continue to pursue full-risk managed care, and are also using managed care alternatives as a way to provide accountable medical homes and expand care management.

2. States want to expand and extend mechanisms for accountable medical homes and managed care into new areas (rural) and populations (aged, blind, disabled, and dual-eligibles).

3. States now realize that they can do much more with their purchasing power than merely secure financial predictability, and they are acting accordingly. Increasing quality, efficiency, and accountability are all important goals.

"Overall, we found that states are expanding the boundaries of traditional full-risk managed care and are using innovative models, including enhanced primary care case management and comprehensive care management, to find the best value in delivering care to Medicaid beneficiaries," Mr. Somers says.

When capitated managed care is not feasible, he says, states are experimenting with alternatives to introduce medical homes and care management to more Medicaid consumers. Enhanced primary care case management uses primary medical care providers to coordinate primary care and approve specialty referrals for Medicaid beneficiaries, and also incorporate features originally developed for capitated managed care programs such as care coordination and quality improvement. Disease management is a strategy of delivering health care services to improve the health outcomes of patients with specific diseases. It often uses telephone interventions, interdisciplinary clinical teams, and patient self-management education. And comprehensive care management is designed to ensure continuity and accessibility of services to overcome rigidly fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with patients' changing needs over time.

He cites as an example a Pennsylvania pilot of Access Plus, an enhanced primary care case management program in rural areas that don't have Medicaid managed care. And he says the state is considering also bringing Access Plus to urban areas as an alternative to capitated managed care, creating opportunities to test how the models can function in the same region. Pennsylvania also is developing health initiatives for smoking and obesity that aim to prevent disease onset.

Several other states are experimenting with care and disease management programs as alternatives to full-risk managed care. Washington recently issued a request for proposals for care management of its high-risk Medicaid population that takes a consumer rather than a disease-focused approach. The new approach is to include predictive modeling to identify at-risk populations and contracts with regional community-based organizations, in addition to a statewide entity, that will work with consumers and primary care providers to manage chronic care needs.

Georgia is launching a new disease management program as a wraparound to its enhanced primary care case management program for the aged, blind, and disabled populations. A disease management vendor will be responsible for analyzing data to produce provider profiles and will be at risk for performance. All care management activities will be the responsibility of primary care providers.

Mr. Somers says states are striving to create medical homes for all Medicaid beneficiaries, noting the term generally refers to an ongoing connection between a beneficiary and the health care system that results in coordination and management of a patient's total health care needs.

Ideally, a medical home will replace the traditionally fragmented, uncoordinated care received under the fee-for-service system that tends to be more costly and less effective, particularly for people with complex or chronic conditions.

According to the survey report, a number of states are interested in increasing access to medical homes by extending some type of managed care delivery system to include populations such as the aged, blind, and disabled, additional benefits such as long-term care, and new regions of a state such as rural areas.

Can't always mandate enrollment

While states acknowledge the benefits of mandatory enrollment, such as higher enrollee participation, ability to reward high-performing plans with default enrollment, and less potential for adverse selection, they also recognize that mandatory enrollment may not always be feasible, at least not initially due to lack of plan capacity in rural areas and resistance from state legislators, providers, or beneficiaries in the newly-targeted populations. In such circumstances, state officials reportedly are considering mechanisms to increase participation in voluntary programs.

"After years of experience implementing managed care for relatively healthy families, states are increasingly realizing that they need to obtain the same level of increased access, quality, and financial predictability for their most complex and costly populations —

ABD (aged, blind, and disabled) beneficiaries," the report says. "The ABD population itself is quite diverse and includes not only the elderly but also persons with physical disabilities and the developmentally disabled, many of whom may also be dually eligible for Medicare and Medicaid, and all of whom may require a range of medical and supportive/social services from multiple providers and in a variety of settings. The complex care needs of many ABD beneficiaries often require additional services that may not typically be included in traditional managed care programs. For example, adults with chronic conditions are more likely to report poor mental health; however, behavioral health services are often carved out of full-risk managed care programs.

"Although a number of states expressed interest in programs that combine behavioral and physical health, few had concrete plans for integrating these services in the near future. In part, this may be because, in many states, behavioral health services are provided through other state or community programs and agencies that are often reluctant to cede those services to a Medicaid agency or managed care plan, making behavioral and physical health integration difficult. Instead, most states seemed to focus on achieving better coordination between current acute care and behavioral health programs and/or other carveouts."

Mr. Somers says Ohio is developing a full-risk managed care program for select ABD beneficiaries to more cost-effectively manage health care services. The case management requirement for ABD health plans will be increased to focus not only on a single condition, but also on the complexities of multiple comorbid conditions. Also, the state's performance measurement set was expanded to better represent the population's unique needs. And the state will use plan-specific enrollment data to risk adjust the health plan capitation rates to ensure an equitable payment structure for plans serving beneficiaries with more complex needs.

Colorado is developing a small pilot managed care program for people with special needs fashioned after the Massachusetts Commonwealth Care Alliance program. Washington plans to transition the ABD population into managed care over the next three to five years. Wisconsin has a mandatory Medicaid managed care program for ABD recipients operating in five counties and plans to expand it into 37 additional counties over the next 18 months.

Mr. Somers points out, however, that not all states have succeeded in implementing managed care strategies for the ABD population. For the last two years, he says, California has attempted to implement enrollment of the ABD population in Medi-Cal managed care, including a scaled-down pilot program, but the state was not able to secure legislative approval or the support of key advocacy organizations.

Sophisticated purchasing

In line with the notion that states are realizing how much they can do with their purchasing power, Mr. Somers says they are becoming increasingly sophisticated in their use of data to improve purchasing strategies. Whether expanding capitated managed care programs or developing new care management approaches, states realize they need better data from their plans and providers, a more advanced data infrastructure, and stronger in-house expertise than was required before.

Whether attempting to increase reimbursement rates to build provider or plan participation, or managing the effects of stagnant rates, states remain concerned with reimbursement issues, the report says.

In an effort to enhance provider participation, especially in rural areas, Maryland hopes to increase provider rates until they are at least comparable to Medicare rates. And after a review of all Medicaid plans ordered by the governor, California obtained rate increases from the legislature for several plans. It also has engaged a consulting firm to make recommendations on its rate methodology that will allow development of rates that are more predictive of plan costs.

Mr. Somers says the researchers heard from state Medicaid directors that they recognize they may not be able to stop the cost increases or shrink their Medicaid budgets, but they can bend those trends by improving outcomes for beneficiaries who are likely to remain on Medicaid for a long time. "States realize," he tells *SHW,* "that 20% of the population accounts for 80% of the costs and only 16% of the costs are captured in managed care for healthy families. So they are progressing to managed care for more complex populations."

Business case for quality

Mr. Somers says states know they have to make a business case for quality, demonstrating that investing in preventing health problems from exacerbating will save money.

State officials look to what's happening in other states to learn what may work for them, Mr. Somers tells *SHW*. He says with 36 governors elected or re-elected in November, there is an opportunity for changes to be made. State budgets seem to be relatively OK, he says, and state officials are looking for the best way to spend the

resources they have available.

"We would advise them to look at high-risk pregnancies that end up with expensive neonatal intensive care and high-risk asthma cases that have a lot of emergency room visits," he says. "There is a high proportion of costs in 1% to 5% of the most expensive people, and state officials should reflect on those people intensively."

Ms. Davis' views are on-line at www.cmwf.org. E-mail her at kd@cmwf.org or telephone (212) 606-3800. The Center for Health Care Strategies report is available at www.chcs.org/publications3960/publications_show.htm?doc_id=422081. Contact Mr. Somers at (609) 528-8400. ■

Fiscal Fitness

(Continued from cover)

The theory behind Cash and Counseling was that if consumers were given control over a cash allowance, and given assistance in managing that allowance, they would select the types and amount of services to best meet their needs and enhance their lives. The program was designed to be budget-neutral, to cost no more per recipient per month than the traditional program.

Enrollment in the demonstration projects was open to interested beneficiaries eligible for personal care services under the state Medicaid plan in Arkansas and New Jersey and under waiver in Florida. Eligible beneficiaries were randomly assigned to direct their own assistance as Cash and Counseling customers in the study group or to receive services as usual from agencies in the control group.

Cash and counseling consumers had an opportunity to receive a monthly allowance to use to hire their choice of caregivers or buy other goods or services needed for daily living. To receive the allowance, consumers had to prepare a spending plan outlining how they planned to use the cash and have it approved by a counselor. They also could ask the counselor for support and advice on managing the allowance.

Costs appear to have been higher in the Cash and Counseling group, particularly in Arkansas, which wanted its program to increase access to paid care. The evaluators said Cash and Counseling apparently increased beneficiaries' access to paid care because, even though there was a labor shortage, they could hire family and friends and this resulted in higher personal care costs for the study group.

"If agencies cannot provide the hours authorized for the care plan, costs per month of services/benefits received may be higher than they would be otherwise," the evaluation said. "In Arkansas and New Jersey, costs per month of benefits were higher for treatment group recipients than for control group recipients, mainly because the control group received less care than they were expected to, at least partly due to severe labor shortages during the study period. The treatment group in these states received allowances approximately equal to the expected cost of obtaining authorized services in the care plan. In Florida, the primary reason for the treatment group's higher costs per recipient month among the nonelderly was that allowance recipients were more likely than those in the traditional program to be reassessed and need more care than was in their original care plan."

It appears that while Cash and Counseling can reduce the need for other Medicaid services, it did not do so consistently across states and time periods. In Arkansas, consumer-directed personal care services reduced nursing facility use and costs more effectively than providing services in the traditional manner. The marked reduction in nursing facility costs was much more pronounced in Arkansas than in New Jersey or Florida.

Mathematica vice president **Randall Brown** tells *State Health Watch* that Arkansas' Cash and Counseling Program, called IndependentChoices, enrolled about 9% of Arkansas's personal care services users in the demonstration. He said those enrolled in the program were less likely than control group members to have nursing facility stays during the study period. For the full sample, he says, the magnitude of the treatment-control difference in nursing facility costs was negative and sizable, but not statistically significant. However, during the three-year study period, there were cumulative savings of about $1,900 — some 15% of the control group mean — in all Medicaid long-term care services, of which nursing facility savings were the largest single component. The long-term care savings rose gradually, from 13% of the control group mean in year one to 17% in year three.

Weigh pros and cons

Mr. Brown says states considering such a program need to weigh the pressure to cut Medicaid costs against their responsibility to provide Medicaid covered services to beneficiaries eligible for them. Personal care costs were higher under Cash and Counseling, he says, because many in the control group traditional program did not

receive any care and because control group recipients received only two-thirds of the hours in their care plans. In contrast, he says, nearly all treatment group members received the full value of their discounted care plans each month, so their actual costs, and the services they received, were close to what they were expected to be.

"Because most programs that reduce nursing facility use do increase public costs," Mr. Brown says, "some have suggested that such programs might be justified because of the benefits they bring to caregivers and their families, rather than because of their cost-effectiveness. Thus, policy-makers might be willing to incur the higher costs for new personal care services applicants to reap Cash and Counseling's sizable benefits [increasing consumers' satisfaction with care, and reducing consumers' unmet needs and caregivers' emotional and physical strain] and to meet their obligation to provide consumers with authorized care."

Mr. Brown said it is unclear whether the source of Cash and Counseling's effects on nursing facility use is increased access to care, or greater flexibility of the personal care services benefit. If increasing access to personal care services is the reason, he says, improving access to care in the traditional program should lead to control group costs for both personal care services and for nursing facility services that were similar to those of the treatment group. However, if the flexibility of consumer direction is the key to reducing nursing home use, Cash and Counseling would yield net savings if control group members received all their authorized care.

Mr. Brown points out to *State Health Watch* that the Arkansas program was not set up to save money, but rather was focused on making people happier and improving their lives, without costing any more money.

In Florida, the demonstration was open to children and adults with developmental disabilities, frail elderly adults, and adults with physical disabilities who were receiving Medicaid home- and community-based services through the state's Developmental Disabilities or Aged/Disabled Adult waiver programs.

Time to plan

Mathematica research analyst **Leslie Foster**, who worked on the Florida program evaluation, said it took many consumers a long time to develop purchasing plans and begin receiving their monthly allowance, if they did so at all. Allowance delays reportedly stemmed from consumers' individual circumstances such as illness or not having family or friends to hire, staff workloads, and procedural delays (such as purchasing plan review and approval), and an initial uncertainty about whether consumers were suitable for Cash and Counseling.

Ms. Foster says consumers who received the allowance used it to meet a variety of care-related needs. Among those receiving an allowance during the nine-month follow-up survey period, 78% said they used it to hire one or more workers. Nearly 60% of the consumers hired family members, although the proportion was smaller for children than for elderly adults. Most workers helped consumers with household and community activities and personal care, and many provided assistance with routine health care and transportation.

Hiring workers was difficult for some consumers, Ms. Foster says. Some 19% of all consumers tried to hire but were not able to. Two-fifths of those who did hire said it was difficult, often because of a lack of interested or qualified candidates. Parents who hired for minor children were more likely to report difficulty than were adult consumers.

Nine months after being assigned to the Cash and Counseling study, 88% of consumers said they would "recommend the program to others who wanted more control over their personal care services." Among consumers who received the allowance, some 60% said it had "greatly improved" their lives and another quarter said it improved their lives "somewhat."

Ms. Foster tells *State Health Watch* the evaluation showed those in Cash and Counseling "did much better than the controls. She says it's important that all who participated in the demonstration project were self-selected and wanted to try the program. The success, she says, might not apply to a mandatory program.

Issue to consider

Mathematica says that states interested in reaping the benefits of Cash and Counseling but concerned about program costs should consider these issues:

1. Recoupment. States might want to adopt procedures for recovering funds consumers don't need. Each of the demonstration states eventually adopted such procedures, which the evaluators said can be implemented fairly if counselors give consumers adequate warning to help them avoid losing funds they may be saving for a legitimate purpose.

2. Reassessments. Programs need to ensure that care plan amounts are no more likely to be increased if consumers receive an allowance than if they participate in the traditional program.

3. Savings on Counseling and Fiscal Services. Arkansas, the

evaluators said, learned a valuable lesson in how to provide counseling and fiscal services in a more cost-effective manner to more accurately reflect the level of effort that providing the services required. When the demonstration began, Arkansas paid the counseling/fiscal agencies $115 per month starting when a consumer enrolled in the program, even though the consumer was not yet receiving an allowance or using counseling or bookkeeping services regularly. The state changed to making a one-time payment after the spending plan was developed, and then paying $75 per month after the consumer started the allowance. Arkansas found the revised arrangement gave the counseling/fiscal agent an incentive to help the consumer complete a spending plan and reduced the state's costs for counseling and fiscal agent services.

4.Allowance discount factor. Mathematica says states should consider adjusting the allowance by multiplying the care plan value by a "discount" factor to ensure it is on par with costs of services that consumers would be likely to receive, on average, from an agency. States also should monitor the discount factor closely and possibly change it, the evaluators said.

A stumbling block

Ms. Foster says administrative details were a major stumbling block for program participants and it will be important for states to look at how much assistance is needed to design a budget and how much help beneficiaries need.

"When the program was designed," she says, "not enough thought was given to how hard it would be for many people to prepare a budget and do the math that is involved. When you get past that, you see that people are able to control their own personal care."

And Mr. Brown tells *SHW* the Cash and Counseling program "is the most effective program I've ever worked with. There has been a nice collaboration between the federal government and the Robert Wood Johnson Foundation and it was a pleasant surprise that the Arkansas program had a significant impact on nursing home care."

Cash and Counseling now has been expanded to Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

Information about Cash and Carry is available at www.cashandcounseling.org. Copies of the evaluation reports are available from Mathematica Policy Research. E-mail Mr. Brown at rbrown@mathematica-mpr.org or telephone (609) 275-2393. E-mail Ms. Foster at lfoster@mathematica-mpr.org or telephone (609) 936-3265. ■

Survey: Americans want Congressional focus on health care

A poll timed to coincide with the shift in the nation's political winds as Democrats take control of Congress found Americans believe access to health care should be the top domestic priority of the new Congress. The poll was sponsored by America's Health Insurance Plans (AHIP), which released the results as part of a campaign for its proposal to expand access to health insurance to every American.

While Americans expressed broad support for a stronger health care safety net, AHIP said, a commanding majority favored reforms building on the current public-private system rather than implementing a new government-run system.

"Americans across the political spectrum are saying that government should take action to improve access to health care coverage, but they do not support a one-size-fits-all approach," said pollster **Whitfield Ayres**, president of Ayres, McHenry & Associates. "Promoting access to health care coverage is an issue Americans agree on regardless of party or ideology."

The AHIP plan would provide access to affordable health insurance coverage for more than 40 million uninsured Americans by expanding eligibility for public programs, enabling all consumers to purchase health insurance with pre-tax dollars, providing financial assistance to help working families afford coverage, and encouraging states to develop and implement access proposals.

AHIP officials said the plan is designed to expand access to health insurance coverage to all children within three years and 95% of adults within 10 years. AHIP estimated full implementation of the proposal would cost the federal government some $300 billion over 10 years.

"The access crisis causes millions of Americans to forgo the preventive care and treatment for chronic illness that they need," said AHIP chairman-elect **George Halvorson**, Kaiser Permanente chairman and CEO. "By ensuring everyone has access to coverage, we can make families more secure, workers more productive and, ultimately, make this a healthier nation."

The plan calls for enacting federal legislation to provide significant financial incentives to states and make changes to federal tax policy to make health coverage more affordable. Key plan elements include:

• expanding SCHIP to make eligible all uninsured children from

families with incomes under 200% of the federal poverty level;

• improving and expanding Medicaid to make eligible all uninsured adults, including single adults, with incomes under 100% of the federal poverty level;

establishing a Universal Health Account to allow all individuals to purchase any type of health care coverage and pay for qualified medical expenses with pre-tax dollars, with federal matching grants for contributions made by families to the Universal Health Account;

• establishing a health tax credit of up to $500 for low-income families who secure health insurance for their children;

• establishing a new $50 billion federal performance grant to assist states in expanding access to coverage.

In the poll results that AHIP said support its proposal, 77% of Americans said they back increasing funding for a health insurance program for children from low-income families that would be paid for by the federal and state governments. Also, 69% support expanding Medicaid to cover all adults, including single adults, who make less than the federal poverty level.

The public (65%) also strongly supports establishing a new tax-free health account for all Americans, which could be used to buy any type of private health insurance, and supports giving a federal tax deduction for money paid by individuals to purchase private health insurance (69%).

A very large 85% said they support giving a tax credit to any low- and moderate-income parents who can show that their children are covered by health insurance. Some 71% support providing incentive grants from the federal government to encourage states to develop programs to provide health insurance coverage for the uninsured, while 63% support modifying the current system rather than replacing it with a government-run health system.

Responding to the AHIP plan, National Association of Community Health Centers vice president for federal, state, and public affairs **Dan Hawkins** said the nation's health centers "know all too well that ending the huge gap between health care's 'haves' and 'have-nots' is a crucially important step toward fixing our seriously broken health care system."

But Mr. Hawkins said it will be equally important to ensure that every American has a health care home. "Today," he said, "there are 35 million people across the country who do not have a personal doctor or health care home, and half of them already have health insurance. These people often end up in hospital emergency rooms or, worse, in hospital wards, because they couldn't get the care they need to keep them healthy or treat illness early and less expensively. Importantly, providing a health care home for each American will help to both improve people's health and lower health care costs, making care more affordable for everyone."

And the Association for Community Affiliated Plans (ACAP), representing safety net managed care organizations, echoed support for AHIP's proposal. "ACAP applauds AHIP in its efforts to stimulate comprehensive action to solve our country's uninsurance problem," said **Margaret Murray**, ACAP Executive Director. "In particular, ACAP agrees that the expansion of Medicaid and SCHIP to cover all low-income adults and children is a logical, efficient solution to persistent uninsurance among these populations."

Darnell Dent, CEO of the Community Health Plan of Washington (State) and ACAP board chairman, said the AHIP plan means that the concept of universal coverage will remain at the forefront of critical national issues. "We hope that other stakeholders, including health plans, the federal and state governments, providers and consumers will participate in what promises to be an ongoing national discussion. ACAP will certainly be on board as this work to cover all people moves forward."

Meanwhile, a poll conducted by the University of Chicago and reported in a *Health Affairs* Web exclusive found that consumers want more coverage and choice, but don't want to pay for them through higher health insurance costs. The pollsters also reported the uninsured are more likely to reject policies that would mandate purchase of health insurance, and that more than 25% of Americans are comfortable with charging obese people higher premiums for their benefits.

They said that Americans have difficulty making trade-offs to reform the health system and make coverage more broadly available, preferring to insist that government and employers address the issues. "Overall, Americans seem to be hoping for a better deal: there is little evidence of self-sacrifice," said coauthor **Daniel Gaylin**. "They want employers and the government to do more to help pay for coverage, but they still want the right to choose from different policies."

More information on the AHIP proposal and the survey findings is on-line at www.ahipbelieves.com. Information on the National Association of Community Health Centers' position is available at www.nachc.com. More information on the Association for Community Affiliated Plans is available at www.acap.org. The Health Affairs report is on-line at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w596. ■

Technology improves North Carolina rural care

The North Carolina Health and Wellness Trust Commission is funding a $360,000 Roanoke Chowan Community Health Center (RCCHC) three-year program to benefit more than 40,000 residents in four disadvantaged counties to demonstrate how technology centered on WebVMC's (Virtual Medical Care) RemoteNurse can help prevent and treat cardiovascular diseases and diabetes.

Remote Nurse is used for in-home monitoring, in-home vital signs monitoring and telehealth kiosks in senior centers, churches, and schools to fight obesity, diabetes, and cardiovascular disease.

"We are in the business of investing in families, in communities, and in North Carolina," said commission chair **Beverly Perdue**, the state's lieutenant governor. "As a commission, it is our goal to make North Carolina the healthiest state in America. By funding important initiatives like these, we are moving closer to reaching this goal."

The Patient Provider Community Telehealth Network began in the fall of 2006 with placement of WebVMC RemoteNurse telehealth systems in homes of patients with cardiovascular disease and diabetes. Later, kiosks in senior centers were used to screen people for risk factors and monitor people at risk and those requiring treatment. The program then expanded to a Latino-based church and was to go next to a local middle school. All services are provided at no cost to patients.

Caregivers and patients are able to use RemoteNurse to monitor risk factors on a device said to be as easy to use as a telephone. Monitoring data are reported to the patient's doctor or nurse automatically, enabling health care providers to check on patients' vital medical signs as often as they feel necessary. WebVMC said that with chronic illnesses like cardiovascular diseases and diabetes, ongoing monitoring is essential to help people stay healthy and compliant with their medical regimen.

"Our region is one of the poorest in the state," said RCCHC CEO **Kim Schwartz**, "with 20% living 100% below the federal poverty level, and our cardiovascular death rate is the highest in the state at 18.5%, and getting worse. With WebVMC's RemoteNurse, we can monitor hundreds or even thousands of people, without requiring them to make the trip to the doctor. By taking this technology to the community—to senior centers, schools, and faith-based organizations—we can track and manage people who receive no or little medical care, and have a positive, immediate, and ongoing impact on their health status."

Interacting as if in person

WebVMC president and chief technology officer **Scott Shepherd** tells *State Health Watch* the RemoteNurse interacts with patients the way a live staff person would. The RemoteNurse has an 8-inch color display that allows patients to interact with the system by touching the screen. There also is a built-in speaker for communicating with patients through verbalized assessment questions and instructions for using the measurement devices. Patients can indicate whether they want the unit to communicate in English or Spanish.

The technology, he says, allows for many more patients to be screened and monitored than would be possible through the old manual process.

According to Mr. Shepherd, success of the program has occurred because the medical community has been working together collegially. "Doctors and other medical professionals bought into the community approach up front," he says.

Health care professionals can access individual patients' monitoring data whenever they want by logging onto a secure web site. The system allows caregivers to set thresholds on answers to assessment questions and measurement values that will result in them being notified by e-mail, interactive pager, or cell phone of any answers or measurement values that don't align with their care plan or fall outside of normal parameters.

Caregivers can ask patients unlimited, multiple choice, yes/no, or scale rating assessment questions that can be customized by disease state. The system generates detailed reports, including measurement results, graphs, notes, and threshold violations based on individualized criteria.

The system has been working for a longer period at Atlanta's Piedmont Hospital and at Texas-based Beyond Faith Homecare. An evaluation of WebVMC's Beyond Faith Homecare effort, found that while hospital readmissions have remained at 28% nationally, and Texas has gone from 33% to 34%, the readmission rate among Beyond Faith Homecare patients has gone down from 31% to 25%.

Also, the percentage of patients who get better at taking medications has increased from 26% to 55%, presumably as a result of the program.

In Atlanta, a community telemanagement program was intended to 1) increase geographical reach and service; 2) increase patient volume, and 3) increase intensity of services.

Positive results

Patient volume increased by a

little more than 50% when the RemoteNurse program opened, an evaluation report says, and patient volumes far outstripped earlier totals. Intensity of service increased 13 times, and outcomes for geographical reach went from an average of 16.3 miles per patient to 39.84 miles per patient.

The evaluation also found that patient satisfaction numbers are high, with 75% of those surveyed saying their RemoteNurse experience was "excellent," and 25% saying it was "good." All survey respondents said they found the remote nurse technology "easy to use."

Information on WebVMC Remote Nurse installations is on-line at www.webvmc.com. Contact Mr. Shepherd at (866) 4WEBVMC [(866) 493-2862]. ■

Report: Fewer physicians are seeing Medicaid patients

Although advocates and politicians are increasing their call for improved access to medical care and medical homes for everyone, the reality is that the proportion of U.S. physicians accepting Medicaid patients has fallen slightly over the past decade, according to a national study by the Center for Studying Health System Change (HSC).

In 2004-05, the HSC report said, 14.6% of physicians reported that they received no revenue from Medicaid, an increase from 12.9% in 1996-97. There also were small increases in the percentage of physicians not accepting new Medicaid patients. The drops came despite increases in Medicaid payment rates and enrollment.

HSC senior fellow **Peter Cunningham** said a more striking trend is that care of Medicaid patients is becoming increasingly concentrated among a smaller proportion of physicians who tend to practice in large groups, hospitals, academic medical centers, and community health centers. Relatively low payment rates and high administrative costs are likely contributing to decreased involvement with Medicaid among physicians in solo and small group practice, he said.

But Mr. Cunningham tells *State Health Watch* it is unclear whether the decline in physician participation creates a problem for Medicaid participants.

"There already has been a fair amount of concentration," he says, "particularly around public hospitals and community health centers. To the extent that facilities become dependent on Medicaid revenue and there are cutbacks, it could lead to decreased access and quality of care."

HSC reports that Medicaid payment rates are considerably lower than payments from Medicare or private health insurance and historically have deterred physician participation in Medicaid. The 21% of physicians who reported accepting no new Medicaid patients in 2004-05 was a rate six times higher than for Medicare patients and five times higher than for privately insured patients, according to HSC's Community Tracking Study Physician Survey. About half of physicians reported accepting new Medicaid patients in 2004-05, compared with more than 70% for Medicare and privately insured patients.

Small part of practice

For most physicians who care for Medicaid patients, Medicaid is a relatively small part of their practice. Among all physicians who provide any care to Medicaid patients, about 60% derive less than 20% of their total practice revenue from Medicaid. But those physicians account for only about 28% of care that physicians provide to Medicaid patients in dollar terms. In contrast, HSC said, about one-fourth of physicians derive 30% or more of their practice revenue from Medicaid, but those physicians account for more than half of all physician care provided to Medicaid patients.

Mr. Cunningham said care of Medicaid patients is becoming increasingly concentrated among the minority of physicians who provide a relatively large amount of care to Medicaid patients. The proportion of all Medicaid physician revenue accounted for by physicians who derived 30% or more of their practice revenue from Medicaid increased from 43.1% in 1996-97 to 51% in 2004-05. And the proportion of Medicaid physician revenue accounted for by physicians deriving less than 20% of practice revenue from Medicaid decreased from about 38% to 28.4%.

"At least part of this shift is explained by the fact that physicians with lower levels of Medicaid participation are increasingly reluctant to take new Medicaid patients," Mr. Cunningham wrote. "For physicians with between 1% and 9% of practice revenue from Medicaid, the percentage not accepting new Medicaid patients increased from 20.7% in 1996-97 to 27.1% in 2004-05. By contrast, less than 3% of physicians who derive 30% or more of their revenue from Medicaid were not accepting new patients, and this has not changed over the past decade."

The survey found the increasing concentration of care of Medicaid

patients is also characterized by a shift away from small, office-based practices toward larger group practices and institution-based practices, including hospitals, academic medical centers, and community health centers. A much higher percentage of physicians in solo or small group practices derive little or no revenue from Medicaid, compared with physicians in institutional settings and other practice types, the researchers said, while more than half of institutional providers derive 20% or more of their practice revenue from Medicaid. However, physicians in solo or small group practices still provide a substantial amount of medical care to Medicaid patients, accounting for more than 40% of all physician Medicaid revenue in 2004-05, compared to 30.5% for institutional providers.

But the trend has been for care of Medicaid patients to shift away from smaller practices over the past decade. Part of that shift reflects the fact that physicians increasingly are moving out of smaller practices and into larger groups and other practice settings. Also, physicians remaining in solo practice or smaller groups are increasingly closing their practices to new Medicaid patients.

Acceptance of new Medicaid patients varies across major physician specialty groups. General internists and family practitioners were most likely to report that their practices are closed to new Medicaid patients, according to the survey, while pediatricians and specialists are the least likely to have closed Medicaid practices.

Mr. Cunningham noted that since children are much more likely to be covered by Medicaid and SCHIP than adults, pediatricians have less ability to opt out of providing care to Medicaid enrollees. Also, many specialists have on-call responsibilities at hospital emergency departments and therefore have less ability to choose the types of patients they see in that setting.

Reasons why

Physicians in large metropolitan areas (with a population in excess of 200,000) were less likely to accept new Medicaid patients than those in smaller metropolitan areas and rural areas. The percentage of physicians in large metropolitan areas not accepting new Medicaid patients increased slightly from 21.3% in 1996-97 to 23.6% in 2004-05. Mr. Cunningham said the much greater concentration of both people and medical providers in large urban areas gives physicians in those areas greater choice about the patients they accept compared with rural physicians. Also, he said, the perceived obligation to accept Medicaid patients may be somewhat greater in rural areas since there are fewer other physicians for Medicaid enrollees to go to, particularly for specialty care.

Mr. Cunningham said the major reasons physicians give for not accepting Medicaid patients include relatively low Medicaid payment rates and high administrative burdens. Among physicians accepting no new Medicaid patients in 2004-05, 84% cited inadequate reimbursement as a moderate or very important reason for not accepting new patients. Bill requirements and paper work were cited by 70% of physicians as reasons for not accepting new patients, while about two-thirds referred to delayed reimbursement. A smaller percentage of physicians cited concerns about having a full practice or the high clinical burden of Medicaid patients.

He said such concerns also likely explain why physicians in smaller practices are increasingly closing their practices to new Medicaid patients. The administrative burden of caring for new Medicaid patients may have increased in recent years, he said, as more states require prior approval for prescription drugs and some tests and procedures. For physicians in solo and small group practices, these administrative costs may be prohibitively high on a per-patient basis given the small number of Medicaid patients they see.

Physicians in solo or small group practices are much more likely to say that billing requirements and

This issue of *State Health Watch* brings you news from these states:

paperwork are their reasons for not accepting new Medicaid patients than are physicians in large group practices and institutional settings, where centralized billing and economies of scale may ease the administrative burden of treating Medicaid patients.

Mr. Cunningham projects a continuing trend of increasing concentration in the future. Physicians, he said, are experiencing considerable financial pressures and declining real incomes because of stagnant payment rates from Medicaid and private payers. Those financial pressures are leading to some physicians reducing the amount of time they spend in volunteer activities and other less profitable aspects of their practice, which may include care of Medicaid patients.

Concentration also is likely to be spurred by the increase in Medicaid managed care enrollment and the formation on Medicaid-only health plans, he said. Enrollment in managed care plans increased from about 40% of Medicaid enrollees in 1996 to 60% by 2004, and is likely to continue to increase in the future.

While Medicaid managed care plans previously included a number of commercial plans that served a mix of Medicaid and privately insured individuals, most Medicaid managed care plans now serve Medicaid enrollees either primarily or exclusively. Physician networks that contract with these plans are likely to include practices that provide a disproportionate amount of care to Medicaid patients, such as clinics and hospital-based physicians, and exclude those that serve relatively few Medicaid patients (solo and small group practices).

According to Mr. Cunningham, fundamental changes to the Medicaid program could effectively reduce Medicaid physician payment rates and decrease physician participation in Medicaid even further. Thus, the Deficit Reduction Act of 2005 is expected to reduce federal Medicaid spending in part by increasing enrollee cost sharing for premiums and health services. While previous laws had limited copayments to $3 or less, the Deficit Reduction Act will allow states to charge some Medicaid enrollees coinsurance amounts up to 20% for some services. If enrollees are unable to pay, as many analysts expect given the low incomes of most Medicaid enrollees, physicians will either have to accept the reduced Medicaid payment or increase their administrative costs to collect from patients.

Since low payment and high administrative costs are already serious physician concerns, some are likely to respond to the higher enrollee cost sharing by closing their practices to Medicaid patients. Mr. Cunningham said enrollees will continue to shift toward providers who are dependent on Medicaid revenue or who are obliged by their mission to serve Medicaid patients.

Download the tracking report at www.hschange.org/CONTENT/866/. E-mail Mr. Cunningham at pcunningham@hschange.org or telephone (202) 484-5261. ■