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## In This Issue



# Integrating services can help high-risk Medicaid beneficiaries

A Center for Health Care Strategies (CHCS) first-of-its-kind Medicaid demonstration project that tested integrating health services for beneficiaries with multiple chronic conditions has found that such efforts appear particularly promising in generating quality improvements and reducing hospital admissions. An evaluation of the project also found that Medicaid purchasers, plans, and providers are willing and able to test groundbreaking models of care for beneficiaries with multiple chronic conditions and that formal measurement of such innovations is critical to quality improvement and to building an evidence base where none now exists.

Currently, CHCS says, consensus is lacking on how to most effectively manage care for adults with three or more chronic conditions. "Adults with multiple chronic conditions have intense and varied care needs, are among Medicaid's highest utilizers, and are among the program's costliest beneficiaries," says CHCS senior vice president **Melanie Bella**, who led the demonstration project. "Through the Medicaid Value Program (MVP), we were able to shed more light on how to tailor care management strategies to best

*See MVP on page 2*

## *No easy answers, but regional payment demonstrations may start 'fundamental change'*

Current health care payment systems create penalties and disincentives across all elements of health care, including preventing illness, diagnosing, treating conditions, and follow-up care. That's the opinion of the Pittsburgh Regional Health Institute's **Harold Miller**, whose Commonwealth Fund-sponsored analysis calls for regional demonstration projects to make progress on payment restructuring.

**Fiscal Fitness: How States Cope**

Mr. Miller tells *State Health Watch* there have been several past efforts to restructure the payment system but the system is so complex and there are so many stakeholders involved that it is difficult to make changes. "Because it's so complex, we've been looking for ways to patch it such as pay-for-performance," he says. "But we've come to realize that the only way to address the problems of inherent incentives and disincentives is through a fundamental change to the system."

The paper cites a number of examples of problems with current payment systems, including:

*See **Fiscal Fitness** on page 6*

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# *MVP*

*Continued from cover*

meet the specific needs of people with multiple serious conditions."

The Medicaid Value Program was the first national effort to examine novel approaches to improve care for adults with multiple chronic conditions. It brought together 10 diverse organizations, including health plans, state Medicaid agencies, provider organizations, and others, to develop and test new strategies for adult Medicaid beneficiaries with multiple chronic conditions.

An evaluation performed by Mathematica Policy Research asked four questions: 1) What interventions did MVP grantees implement and what were they trying to achieve with the interventions? 2) To what extent were MVP grantees successful in implementing their interventions and what factors facilitated or impeded this? 3) Did the interventions achieve the outcomes or impacts sought? If not, why? And if so, how? What factors could have made the interventions more successful? And, 4) How generalizable is the MVP experience? That is, what was learned about the various models as well as their replicability and utility?

### Different populations targeted

Target populations for the 10 programs varied, with four grantees targeting patients with diabetes and comorbidities, three focusing on mental health and substance abuse care, and two focusing more generally on those at high risk for adverse events and clients with high overall costs (and multiple chronic medical conditions). The remaining grantee was more methodologically focused on comparative assessment of health risk screening tools to support system redesign.

Of the nine care-focused programs, seven targeted their interventions on patients, with all but one using a case management and coordination model to improve patient care. The exception augmented an existing disease management program with in-person patient education. Two grantees targeted their intervention on providers, in the hopes of improving patient care quality.

Only two interventions ran for less than 12 months. The rest had an average reporting period of 15 months. Two had at least one year of operational experience before the start of MVP.

The evaluators found that grantees generally were able to implement the interventions they sought and create the partnerships needed to support those interventions, although refinements were made in some cases.

Start-up delays were common. Grantees varied in the size of intervention group they aimed for from the start, with two substantially larger than the others. The small size of target populations for many interventions reflected a combination of inherently small numbers of people with certain complex conditions, limited grantee resources, and challenges associated with recruiting for some of the interventions.

### Factors influencing success

Evaluators said they identified at least five factors that influenced implementation success in all the programs. First was strong leadership from the top of the organization. Second, grantees succeeded most at implementation in environments where conditions were favorable with no competing priorities or constraints that limited attention and resources for the intervention. Third, buy-in from staff, patients, and providers is critical. Fourth, support

and leadership by the Medicaid agency is critical for many grantees to open doors because the agency has authority over program policy and operations. And fifth, the ability to standardize the intervention early on, with highly specified intervention activities and protocol documentation, made it much easier to communicate what was needed and avoid later delays or confusion among those who implemented the interventions.

The evaluators said the replicability of an intervention depends on: 1) the clarity and specificity of intervention activities; and 2) its organizational and environmental context. Most grantees thought their interventions could be replicated and the evaluators tended to agree. But they said the more challenging issue involves whether it makes sense to encourage replication. Grantees generally saw value in encouraging replication even if they were not able to show empirical evidence on outcomes or business returns.

### Positive results

On balance, the evaluators said, MVP has been a positive program on several dimensions:

1. From a process perspective, MVP demonstrated the value of using logic models and process measures to help grantees be clearer about their interventions and what they hoped to achieve.

2. MVP generated evidence suggesting that well-conceived efforts to better integrate care across the range of services required by beneficiaries with multiple chronic conditions have promise.

3. The findings show it is not just what the intervention is that matters, but also that the intensity of the

## *Parties, president try to hammer out SCHIP compromise*

As this issue of *State Health Watch* was finalized, some members of Congress were working behind the scenes to hammer out a compromise that could gain enough Republican votes to overcome a presidential veto. And President Bush signaled a willingness to accept some program expansion.

The president and other critics of a Democrat-sponsored, $35 billion SCHIP spending increase said they could support expanding coverage to families of four making up to 300% of the federal poverty level ($62,000 per year), but wanted to limit states' ability to expand coverage even more.

Observers say about 35 states ignore some income when determining who qualifies for the health coverage. Thus, many states exclude child support payments when calculating income, while others deduct child care expenses.

President Bush initially proposed a $5 billion increase in SCHIP spending over five years, but congressional Democrats countered with a $35 billion boost that he vetoed.

A second bill tried by the House of Representatives would have added some 3.9 million uninsured children to the rolls by 2012. The president promised to veto that bill as well if the Senate didn't make major changes.

Sen. Chuck Grassley (R-IA), ranking member of the Senate Finance Committee, an outspoken GOP supporter of SCHIP expansion, reportedly was working with House Republicans and some Senate Democratic leaders on an amendment to meet the demands of a group of House Republicans who said they might support a changed bill.

In addition, House majority leader Steny Hoyer (D-MD) and Democratic caucus chair Rahm Emanuel (D-IL) met with Republican lawmakers to see if a compromise could be reached. While additional meetings were planned, some Republicans said it appeared there was not enough flexibility from Democrats to resolve questions on proof-of-citizenship guidelines, income limits, and mandatory targets for enrolling children in families with less than 200% of poverty.

After the second House bill was considered, a group of 36 Republicans sent a letter to Speaker Nancy Pelosi (D-CA) outlining six changes they wanted in exchange for their support. Observers said their top requests were that the measure include a mechanism requiring states to ensure that most children in families earning less than twice the poverty level are covered by SCHIP or Medicaid before expanding coverage to higher-income families; that all adults, including parents, be excluded; and that it include stronger safeguards against illegal immigrants enrolling in SCHIP.

Some Democrats, including members of the Congressional Black Caucus, warned their leaders that too much negotiating could erode their support of the bill. Overall, some observers saw the beginnings of a change in the political dynamic in which Democrats have been uncompromising on issues such as SCHIP. They said Democratic leaders may believe the need to show they can govern may trump the fear that too much compromise will anger their political base. ■

intervention is likely to be important to improving outcomes for patients with multiple chronic illnesses.

4. MVP brings to light what could be some difficult or even insurmountable challenges in building a strong empirical evidence base on ways to improve care for adult Medicaid beneficiaries with multiple chronic illnesses.

Arising out of those conclusions are three recommendations:

1. Organizations should favor multifaceted yet well-targeted interventions with sufficient intensity to affects outcomes. The evaluators say the populations targeted by MVP interventions have complex conditions and multiple needs and they are involved with the health care system in a number of ways. It seems important, they say, to focus on interventions, such as the Washington state program (**see article, below**), that have the potential to drive change in ways that align processes to reinforce improvements in care and outcomes.

2. Greater emphasis should be put on learning and design before testing. The evaluators found that often changes in care processes were being implemented for the first time or conceived without benefit from existing experience elsewhere. Diversity also limited what grantees could learn from one another or others could learn by examining the collective experience. Given the challenges illustrated by MVP in assessing the effects of interventions, the evaluators say, it would be valuable to spend substantially more time exploring potential interventions for their promise so efforts and tests could be focused on those that are most promising.

3. Multisite tests of the most promising interventions should be considered. Creating change through small-scale interventions that are narrowly focused geographically or defined such that they reach small numbers of people, however sick they are, makes it hard to test interventions, the evaluators say. If there are particularly promising interventions, it could be strategically valuable to focus resources on bringing them to scale for rigorous testing. And beyond the numbers, multisite tests also add insight on an intervention's replicability across sites, especially if there is sufficient data to assess effectiveness at the site level as well as across sites.

Ms. Bella tells *State Health Watch* a number of core elements of effective care models emerged from the MVP demonstrations, including service integration, particularly around physical and behavioral health; multidisciplinary care teams led by a "go-to" person; and consumer engagement.

### Evaluating success not an issue

Problems in measuring success, Ms. Bella says, were not an issue for many of the MVP teams, as seen by the fact that they intend to continue funding the interventions into the future. "Given the dearth of evidence on best practices for managing care for these complex populations, we are finding that limited evidence is often sufficient to engage the interest of other organizations that recognize the need to identify better, or promising, models of care for these consumers," she says.

In an ideal world, Ms. Bella says, the evaluators' three recommendations above would be addressed in unison. She notes that multifaceted interventions aiming to improve quality of care through combinations of strategies at multiple levels hold the greatest promise for improving outcomes. However, she says, many organizations need to start somewhere and should consider incremental approaches to improve quality in addition to more comprehensive, often resource-intensive, approaches that may not always be feasible to implement all at once.

For the Center for Health Care Strategies, she says, the second and third recommendations confirm the strategy for identifying and disseminating best practices for managing care for those populations representing highest needs and highest costs. That strategy has two elements, she says: identifying and testing emerging models of care through pilot demonstrations and, for those models that suggest promise in pilot efforts, implementing larger multisite demonstrations incorporating rigorous evaluations to confirm scalability and to build empirical support for their spread.

*Download the Medicaid Value Program report at www.chcs.org. Contact Ms. Bella at (609) 528-8400.* ■

## *WMIP integrates services for aged, blind, and disabled*

The pilot Medicaid Value Program that drew the most attention from the Center for Health Care Strategies and Mathematic was the Washington Medicaid Integration Partnership (WMIP), which brings together primary care, mental health, substance abuse, and long-term care services for categorically needy aged, blind, and disabled (ABD) Medicaid beneficiaries in Snohomish County, north of Seattle.

The program is operated by Molina Healthcare of Washington, a for-profit HMO focused on Medicaid and other vulnerable populations, under contract to the

state Department of Social and Health Services (DSHS). State officials say the primary motivating factor underlying WMIP implementation was the disproportionate use of health care by these beneficiaries, who tend to have complex health profiles and are the fastest growing segment of the state agency's client base. Officials say ABD Medicaid clients in Washington are 15% of the total Medicaid caseload but account for 35%-40% of total fee-for-service expenditures.

According to state officials, before WMIP, ABD clients received substantial amounts of inappropriate care in emergency departments and hospitals due to lack of care management by physician and nursing facilities and because patients were not aware of or did not know how to access the care available for them.

Because the state agency was not sure it could integrate all the services at once, it chose to phase them in. Thus, WMIP clients were able to receive both primary and substance abuse care beginning in January 2005. Mental health care was added in October of that year and long-term care was added a year later in October 2006. Under WMIP, enrollees are eligible to receive all the same medical services that they would have received under fee-for-service Medicaid, except that Molina provides a central point for care coordination and management.

Molina's care coordination program includes health risk assessment, monitoring of patient symptoms, and education. Its care coordination teams coordinate home care, inpatient care, skilled nursing facility placement, long-term care, disease management, mental health care, substance abuse care, durable medical equipment, transportation, and day healthcare for patients in WMIP. The degree of patient contact varies from patient to patient depending on the patients' conditions. At a minimum, Molina staff contact the most stable patients once per quarter. Patients whose conditions are more fragile or require closer monitoring (some 30% of WMIP patients) are contacted at least twice per month and more often if needed.

### *Patient survey responses*

The state agency measured claims-based outcomes and self-reported outcomes from surveys of enrollees and disenrollees, and compared results with a group of similar patients in other counties. Patient surveys identified reasons for WMIP enrollment or disenrollment and assessed patient satisfaction. Claims-based outcome measures included physician visits, inpatient admissions, emergency department use, and prescriptions filled. The agency also reported on the proportion of patients with mental health or substance abuse problems who used mental health and chemical dependency treatment and mental health hospital admissions.

Outcomes measures reported to the Center for Health Care Strategies in April 2007 suggested that WMIP appeared to have slowed the rate of inpatient admissions and mental health hospital days. But other measures were either flat or counter to expectation.

Results for mental health/substance abuse service utilization outcomes also were mixed. Mental health prescriptions filled rose slightly more in the intervention group than in the comparison group, suggesting to the evaluators that intervention group members were receiving prescriptions required to manage their behavioral issues, but at only a slightly better rate than the comparison group. Less encouraging to the evaluators, the proportion of patients with identified needs for alcohol or other drug treatment services who received these services rose at a slower rate in the intervention group compared with the comparison group. Molina staff reported that WMIP enrollees likely underreported substance abuse/chemical dependency issues, making it challenging to provide services to patients who failed to report a need for them.

Survey results indicated that WMIP improved client satisfaction with some aspects of care delivery (and reduced it for others) compared with a comparison group, and improved care coordination for many intervention group members. WMIP enrollees reported improved satisfaction with some aspects of care delivery, including wait times for routine care appointments, delays while waiting for health care approval, and problems with customer service or paperwork. However, enrollees were less satisfied with other aspects of care than their fee-for-service counterparts, including help when calling health care providers during regular office hours, help for urgent care right away, needed treatment or counseling for a personal or family problem, and prescription drugs. On average, WMIP enrollees who responded to the survey rated their health care and health plan lower than fee-for-service clients.

### *Significant disenrollment*

Of the more than 5,000 members enrolled in WMIP in December 2004, nearly 2,000 chose to disenroll within the first month. Enrollment steadily fell to 2,180 active participants by June 2005 and 1,700 by March 2006, as patients lost Medicaid eligibility or moved out of the service area.

After the agency identified additional eligible patients in early 2006, enrollment rose to nearly 2,700 in

June 2006 and remained steady through April 2007. Agency staff said the primary reason for enrollment stabilization was addition of a staff member to manually search for new or reconnected clients to be auto-enrolled into WMIP, a task the data system is unable to perform automatically.

WMIP conducted a disenrollee survey in Spring 2006 and found that more than half of those who left either lost Medicaid eligibility or moved away, while 37% opted out voluntarily. The primary reasons people opted out of WMIP included problems with access to providers and prescription drugs. Thus, 36% of those who opted out said their regular doctor was not affiliated with Molina Healthcare, 24% said they had to travel further to visit their Molina Healthcare physician, and 18% reported issues with the language spoken by their Molina physician. Some 30% said a family member or case worker influenced their decision to leave.

DSHS care coordinator **Alice Lind** tells *State Health Watch* preliminary cost-benefit data show some positive differences on measures such as avoiding emergency department use and inpatient admissions. While trends in both the intervention and comparison populations went up, she said, the increase was not as much for WMIP patients.

Ms. Lind says DSHS and Molina identified two general categories of implementation barriers they confronted as they put the program in place. First were internal barriers created at the state agency level such as claims being paid from different systems, eligibility information being kept in different systems, and systems not talking to each other and requiring manual work-arounds.

At the community level, concerns were raised because Molina is a for-profit health plan and there were questions about taking money from a not-for-profit system to go to a for-profit plan. There also were many stakeholders involved who wanted to be sure the changes would benefit clients.

Looking at program evaluation, Ms. Lind says it was challenging to find meaningful comparison groups. In addition, she says, while there is a lot of information available on quality measures, there isn't much that has been tried and tested. It's particularly difficult, she says, to develop quality measures for an integrated system rather than for some of the system's component parts.

She says she believes the program is worth replicating but cautions it needs committed executive-level leadership and legislative political will to bring it about. The Washington legislature has given its approval to doubling potential enrollment in WMIP and the state plans to expand it while trying to fix the problems that have cropped up.

*Mathematica's evaluation is available online at www.chcs.org. Contact Ms. Lind at (360) 725-1629.* ■

# *Fiscal Fitness*

*(Continued from cover)*

1. Fee-for-service systems generally don't pay adequately (or at all) for many preventive care services. Also, low payment levels are believed to discourage doctors from entering primary care.

2. Payers often don't have an incentive to invest in preventive care since the payoff in terms of better health and lower costs occurs in the future and may accrue to other payers.

3. Fee-for-service systems may not adequately pay for time needed by a provider to make an accurate diagnosis and develop an appropriate care plan and discuss it with the patient. Providers are not financially penalized for ordering more tests, regardless of whether the tests are necessary to make an accurate diagnosis/prognosis.

4. Fee-for-service payment systems reward providers for supplying more services, even if the services are unnecessary or are of low value. Payment systems generally pay for services regardless of whether all of the processes recommended in clinical practice guidelines are performed by the provider.

5. Under most payment systems, providers are paid more for patients experiencing adverse events particularly serious adverse events resulting in multiple complications.

6. Payment systems reinforce fragmentation of care by paying multiple providers for multiple services or tests for the same patient, regardless of whether care is coordinated or duplicative.

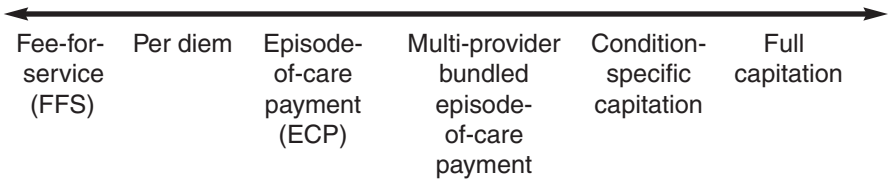
7. Current payment systems don't pay hospitals or doctors more to manage needs of patients with complex conditions after discharge from the hospital or to work proactively to encourage and assist patients in complying with post-discharge instructions to improve outcomes and prevent rehospitalization.

8. Patients generally don't have a financial incentive to adhere to prevention and disease management recommendations that could improve outcomes and reduce health care costs.

9. Many payers don't have mechanisms for encouraging or directing patients to providers who supply better value.

Mr. Miller says any redesigned payment system should try to meet 12 goals: 1) enabling and encouraging providers to deliver accepted procedures of care to patients in a

**Figure 1. Continuum of Health Care Payment Methods**




*Source:* Miller HD. *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform.* New York City: The Commonwealth Fund; September 2007.

high-quality, efficient, and patient-centered manner; 2) supporting and encouraging providers to invest, innovate, and take other actions that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs; 3) not encouraging or rewarding overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or rehospitalization, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires; 4) not rewarding providers for undertreating patients or for excluding patients with serious conditions or multiple risk factors; 5) not rewarding provider errors or adverse events; 6) making providers responsible for quality and costs within their control, but not for quality and costs outside their control; 7) supporting and encouraging coordination of care among multiple providers and discouraging providers from shifting costs to other providers without explicit agreement to do so; 8) encouraging patient choices that improve adherence to recommended care processes, improve outcomes, and reduce costs of care; 9) not rewarding short-term cost reductions at the expense of long-term cost reductions, and not increasing indirect costs to reduce direct costs; 10) not encouraging providers to reduce costs for one payer by increasing costs for other payers, unless changes bring payments more in line with costs for both payers; 11) minimizing administrative costs for providers in complying with payment system requirements; and 12) having different payers align their standards and methods of payment to avoid unnecessary differences in incentives for providers.

According to Mr. Miller, issues that need to be addressed in redesigning health care payment systems include the basic payment method that should be used for care, whether payments for multiple providers should be bundled together, how payment levels should be determined, what performance standards should be set and whether performance incentives should be added to the basic payment method, and whether specific incentives should be provided to patients on choice of providers and participation in care.

"Unfortunately," Mr. Miller says, "there are no easy answers regarding which options offer the best resolution for these many issues. Uncertainty exists due to the fact that there have been relatively few cases where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted."

His recommendation is that a wide variety of payment demonstrations be developed, implemented, and evaluated. "Just as experimentation and evaluation is a hallmark of evidence-based medicine, experimentation and evaluation will also likely be needed to develop the most effective cure for the ills of the payment system,' he says.

Mr. Miller suggests that leadership for payment reform demonstrations come from the regional level rather than the national level because health care is a fundamentally regional enterprise since most providers and even most payers operate exclusively or primarily in metropolitan regions, states, or multistate areas.

"While payment demonstrations can and should be pursued at the regional level, this does not mean that payment reform should be a parochial enterprise," Mr. Miller says. "Indeed, just as medicine itself advances the state of the art through local innovations that are supported, replicated, and evaluated nationally, so too can payment reform be more successful if there is national support for the development, evaluation, and replication of regional payment demonstrations."

Mr. Miller tells *State Health Watch* it will help if the payment demonstrations piggyback on efforts already underway to improve health care "There can be variations around the country," he says, "so long as the incentives are in line so providers don't have to respond to different payers' programs."

The national payers such as Medicare and Medicaid are important, he says, and it would be helpful if Medicare would support a demonstration tailored to what regions want to do with their other payers. He says it's not yet clear whether Medicare and Medicaid can allow regional variations.

Commenting on Mr. Miller's analysis in an opinion column, Commonwealth Fund president

**Karen Davis** says one approach would be to move the health system toward "blended payments," in which payment for hospitals and physicians includes fee-for-service payments, per-patient payments, and performance bonuses. Hospitals receiving a per-patient episode fee would be encouraged to provide transitional care to reduce the risk of rehospitalizations, and physician practices would be encouraged to set up their offices as medical homes that patients could join to receive coordinated, accessible care. Medical homes, in turn, should lead to improved chronic care management, ensure patients receive preventive care, and offer accessible, off-hours care, she says. They also could reduce the number of emergency department visits.

Ms. Davis cautions that it's not realistic to tell hospitals and doctors that they must improve quality if by doing so they are likely to lose money. She says Commonwealth Fund-supported research into the "business case" for quality has shown that even in programs that save money, the savings are not likely to accrue to the doctor or hospital implementing the changes. And, she says, some patients and physicians are concerned that there will be an incentive to skimp on care if we move away from fee-for-service payments (**see chart, p. 7**).

"Experimentation with different payment reforms is clearly needed," according to Ms. Davis, "and this can be accomplished through various types of demonstrations. If Medicare and Medicaid provide leadership here, more private insurers would be encouraged to follow suit. Once new payment methods are in place, we can observe their effects, see what works best, and give providers time to learn how to improve through them. We must start testing different approaches now to begin to rein in costs and to make sure we are paying for the best available care, not just more services."

*The report is available online at www.commonwealthfund.org/publications/publications_show.htm?doc_id=522583. Contact Mr. Miller at (412) 803-3650. Ms. Davis' analysis is online at www.commonwealthfund.org/aboutus/aboutus_show.htm?doc_id=559687. E-mail her at kd@cmwf.org.* ■

# Medicaid, SCHIP expansion cover uninsured

States and communities wanting to quickly expand health care coverage to the uninsured can profit from experiences in Massachusetts and California, according to a study conducted for the Association for Community Affiliated Plans (ACAP) that found that expansion of Medicaid and SCHIP through Medicaid health plans is an effective way to cover the uninsured. The study found that states are better served to cover low-income uninsured individuals by building on a platform of Medicaid managed care plans already operating in their states rather than subsidizing purchase of commercial health insurance through tax credits or other incentives for low-income people.

"States looking to cover low-income uninsured people don't have to look too far," says ACAP executive director **Margaret Murray**. "The Medicaid plans are right in their backyard and ready to work with the states on expansion programs."

The report focuses on Massachusetts and California, two states that are breaking new ground in expanding coverage to uninsured residents. It provides case studies demonstrating how Massachusetts and several California counties capitalized on existing Medicaid health plans as "turnkey" solutions to quickly, efficiently, and economically provide coverage to low- and moderate-income people.

The Lewin Group report says there are many reasons to select Medicaid health plans for the roles they are playing or are proposed to play in reform efforts, including experience in serving low-income higher-need clients; experience working with state government purchasers; administrative experience, including efforts to improve quality and access and to control costs; and existing provider networks that include safety net providers and other providers that have demonstrated an ability and willingness to serve low-income populations.

Even with these positive points, there are challenges faced by the plans, including limited or no experience in marketing to groups of potential new enrollees, collecting premiums, advertising, enrollee cost-sharing, and operating multiple benefit plans.

### Coverage program use not simple

The study says creating a coverage program is not as simple as "build it and they will come," because people who are not used to having a regular source of coverage may not come forward. The researchers say a successful program helps individuals enroll, access care, and navigate the system.

Several California counties have developed county-level children's health initiatives known as Healthy Kids. They generally are funded by a

combination of local funds, tobacco tax, foundations, grants, and plan reinvestment. The programs expand coverage for low-income children not covered by Medi-Cal or Healthy Families (California's SCHIP program). In each county, a Medicaid health plan is the sole provider.

For the Massachusetts Commonwealth Care program, eligible people must be at or below 300% of the federal poverty level, uninsured, age 19 or older, and not eligible for Medicaid or SCHIP.

The five programs covered in the report identified three specific operational areas in which purchasers can design programs that effectively leverage the experience and resources of existing Medicaid health plans—provider networks, health care operations, and outreach and enrollment. The plans also described the unique benefit of a purchaser's decision to use Medicaid and SCHIP health plans to provide coverage in a health care expansion program—the ability to provide continuity of care for persons moving among public programs due to income fluctuations, and to cover children in a family that may qualify for different programs due to age or citizenship status. The Medicaid health plans interviewed also noted their deep commitment to serve the uninsured and low-income populations, evidenced by an intensive resource commitment to public programs, close links with public purchasers and partners, and not-for-profit status.

### Many challenges

The report says a longstanding challenge for both low-income persons and the programs serving them is that income-based enrollment criteria, coupled with fluctuating income, lead to unstable enrollment. Thus, persons may gain and lose eligibility for various programs as their financial situation changes, which can have negative affects on health status. Children can also move between programs as they age, and different members of the same family may qualify for different programs due to age or citizenship status, which also can cause confusion for families.

But expansion programs served by the plans that participate in other programs for low-income people such as Medicaid and SCHIP offer enrollees a chance for stability in coverage and the potential for better continuity of care over time. The study says Medicaid health plans that participate in Medicaid and SCHIP are in a unique position to provide stability across programs by offering access to the same providers and care management services. Medicaid health plans also are able to track members' needs and care across programs despite members' movement between the public health insurance programs.

To the extent that existing policies and infrastructure are not appropriate and new policies or protocols must be developed, both the purchaser and health plans can use their existing relationships to accomplish necessary development steps. Lewin says this is particularly helpful as any new program, and especially one under pressure to get started quickly, will be forced to make quick decisions that may then need to be revised or reversed and participating plans must deal with a certain amount of uncertainty and change.

Programs to cover the uninsured may have characteristics that are different from current Medicaid and SCHIP programs. Thus, Medicaid health plans may not be able to leverage their existing infrastructure or may need to make significant modifications. Lewin analysts say central is the need to modify management information systems to address unique aspects of the expansion initiatives. While commercial plans or plans that operate in multiple states may be familiar with developing customized systems applications for different programs or product lines, this may be unfamiliar territory for some Medicaid health plans that serve only one or two local programs. Policymakers designing an expansion program that looks similar to Medicaid or SCHIP may view Medicaid or safety net health plans as strong candidates for participation in the program. But to the extent that other design characteristics are a policy priority, such as premiums and cost-sharing or a benefit structure similar to state employees or other commercial groups, commercial plans may have an advantage.

### Plan successes

Ms. Murray says the plans were able to: 1) help states implement an expansion quickly; 2) leverage existing safety net provider relationships; 3) build on established operations to serve the health needs of low-income people; 4) use their experience in outreach and enrollment strategies; and 5) support continuity of care for people in different programs.

Ms. Murray told a news conference announcing the study results that Healthy Kids and Commonwealth Care were designed to leverage existing infrastructure to provide a quick start-up. From the purchaser perspective, the Lewin study says, existing infrastructure such as the enrollment broker, reporting, and monitoring, could be adapted to a new program.

Because low-income or uninsured persons already may rely on traditional safety net providers, health plans that contract with or are owned by networks of safety net providers can quickly convert an existing network or develop a new

network to serve the expansion group.

A third advantage is that Medicaid health plans have member services, care management, and outreach staff experienced in assisting low-income person who may face a variety of barriers to care. Also, safety net or community-based health plans may be able to co-locate outreach and member services at provider and community locations.

It is known that low-income or uninsured people can be difficult to identify and enroll in programs and it helps that Medicaid health plans have experience identifying and informing potential members and also have linkages with local organizations. Thus, the report says, the plans can assist purchaser marketing and outreach efforts and can promote availability of coverage for members of a family who are eligible for different programs.

Finally, Medicaid health plans support continuity of care for persons in different programs. Medicaid health plans participating in multiple programs can track members as they move between programs, promoting continuity of care, and can simplify coverage for different family members and create a single source of information and care.

Medicaid health plans participating in the Massachusetts and California health coverage expansion programs made several recommendations for Medicaid and safety net health plans that want to participate in similar expansion programs, and for policy-makers considering coverage program options. The recommendations include:

1. influencing the planning process;
2. collaborating with state and county legislators, regulators, and community organizations;
3. incorporating extensive evaluation into the program design;
4. securing organizational commitment and build on existing efficiencies.

*Download the study and related materials at www.communityplans.net. Contact Ms. Murray at (202) 331-4601.* ■

# States making strides in technology, info exchange

States are making progress in implementing health information technology (HIT) and health information exchange (HIE) initiatives that have the potential to reduce health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information, according to a new report from the Department of Health and Human Services' Office of Inspector General (OIG).

The OIG says 12 state Medicaid agencies (Florida, Iowa, Kansas, Louisiana, Mississippi, Missouri, Montana, Pennsylvania, Tennessee, Vermont, Wisconsin, and Wyoming) have implemented a variety of HIT initiatives, including claims-based electronic health records, electronic prescribing, remote disease monitoring, and personal health records initiatives. And many other state Medicaid agencies are in the process of developing similar initiatives.

Likewise, some 25 state Medicaid agencies (Arizona. California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, Rhode Island, Tennessee, Utah, Vermont, Washington, West Virginia, and Wisconsin) are involved in planning and developing statewide HIE networks that will allow for secure exchange of health care information. The networks' goal is to develop a statewide infrastructure to support widespread use of HIT and allow health care providers and payers in the states to securely exchange clinical information. Also, 13 state Medicaid agencies include Medicaid Information Technology Architecture (MITA) as part of their HIT and HIE planning. MITA is a framework developed by the Centers for Medicare & Medicaid Services to help states modernize their Medicaid information systems.

The OIG report says HIT is used to electronically collect, store, retrieve, and transfer clinical and administrative information. HIE is defined as sharing health care information electronically among disparate health care information systems. HIE requires each participant in an HIE network to agree to certain information-sharing policies and procedures. HIE is needed to make HIT, such as electronic health records and other technologies, become fully interoperable, meaning that health care providers can not only view or read data from another entity, but also can modify them and exchange them with other users.

### Funding available

State Medicaid agencies can receive funding for HIT and HIE initiatives from Medicaid matching funds for administrative expenditures and from federal grants. The federal match for administrative expenditures is generally 50%, the OIG says, although it is higher for certain administrative functions.

Nine state Medicaid agencies (Iowa, Kansas, Louisiana, Missouri, Montana, Pennsylvania, Tennessee,

Vermont, and Wisconsin) have implemented claims-based electronic health record initiatives for Medicaid beneficiaries. Some 27 additional Medicaid agencies are in the process of developing electronic health record initiatives. The nine current programs all rely on Medicaid claims data and contain clinical information about patients such as prior diagnoses, medical procedures performed, and prescription history. The information is derived from procedure and diagnosis codes contained in the Medicaid claims data. In all but one case, authorized health care providers access the information through a secure web portal. Four of the initiatives also have begun to incorporate a limited amount of data from other sources such as public health department immunization records.

Unlike interoperable electronic health records in which providers exchange clinical information, these initiatives enable providers to only view information derived from prior Medicaid claims. Providers cannot directly enter information into the record or exchange their clinical records with other providers.

The nine records initiatives are targeting different Medicaid populations and providers. Four have records available for the state's entire Medicaid population, three have records available for Medicaid beneficiaries participating in the state's fee-for-service program, one is limited to Medicaid beneficiaries participating in a managed care program, and one is limited to certain beneficiaries who are chronically ill. The initiatives also target different types of providers, with four of them allowing all enrolled providers to access beneficiaries' records, while the remaining five allow only specific types of providers to access the information, such as those in emergency departments.

State Medicaid directors told the OIG their primary goal in developing electronic health records was to improve quality of care by providing more information to clinicians about beneficiaries' medical histories. They believe that having access to a beneficiary's prior diagnoses and treatment history enables clinicians to provide better care. They also said the initiatives may prevent Medicaid fraud, waste, and abuse.

### *Security, privacy issues challenge*

A major challenge in implementing electronic health record initiatives has been developing security and privacy policies, the directors said. In particular, notifying beneficiaries about how their information will be used and developing procedures to handle sensitive data, such as mental health, substance abuse, and HIV/AIDS information, have been challenging.

The majority of the 27 state Medicaid agencies with planned electronic health record initiatives will develop claims-based programs similar to those already in existence. In a few cases, the OIG reports, Medicaid agencies are attempting to develop more interoperable records that will rely on HIE networks. And in two cases, the agencies are planning to replace their claims-based initiative with more interoperable records that will include data from other sources and allow providers to exchange a wider range of clinical information.

Five states (Florida, Kansas, Mississippi, Missouri, and Tennessee) have developed e-prescribing initiatives and another 21 states are in the process of developing programs. The current efforts allow providers to electronically prescribe medications and to view beneficiaries' prescription histories derived from Medicaid claims data. They also give providers information about the states' Medicaid drug formulary and potential drug interactions. Providers can access the systems through web portals or through hand-held personal digital assistants.

Medicaid directors said their goals for e-prescribing included avoiding adverse events due to drug interactions or errors, limiting drug-seeking behavior by enabling physicians to view medication histories, increasing adherence to the Medicaid formulary by enabling providers to view formulary information, and monitoring physician prescribing behavior.

The directors said they ran into security and privacy problems similar to those experienced with electronic health records. Two directors reported difficulty expanding their initiatives because some pharmacies don't have the capability to receive prescriptions electronically.

### *Remote monitoring initiatives*

The state Medicaid agencies in Missouri and Wyoming have implemented remove disease monitoring initiatives for selected Medicaid beneficiaries and three additional states are in the process of developing such initiatives. In Missouri and Wyoming, beneficiaries have been provided an electronic telemonitoring device for use in their homes. The devices collect health information and monitor beneficiaries' vital signs and other medical statistics daily. In Missouri, the device is a central processing unit that can incorporate an array of technologies such as an automated blood pressure cuff or a scale. The Wyoming device asks beneficiaries questions about their health status such as weight changes or test results. In both initiatives, the information gathered by the units is transmitted through telephone lines to providers who are charged with monitoring beneficiaries' health status. When problems are detected, the monitoring team follows up with the beneficiary's primary care provider.

Both initiatives are available primarily to chronically ill beneficiaries who might benefit from daily monitoring. The beneficiaries commonly have conditions such as diabetes, asthma, and chronic heart failure. The directors of the two agencies said their goal for the program is to improve patient outcomes and reduce emergency care and hospitalizations. They also think the initiatives could reduce the total cost of care for participating beneficiaries.

In terms of implementation challenges, one agency director cited the difficulty in maintain current telephone numbers for participating beneficiaries, while the other referred to challenges in measuring the initiative's impact.

No state Medicaid agency now provides personal health records to Medicaid beneficiaries, although 13 agencies reported they are planning to develop such initiatives. Most are expected to be claims-based, much like the electronic health records, although these records will be maintained by beneficiaries, usually through a portable computer drive or a web portal.

Some 25 state Medicaid agencies are planning and developing statewide HIE networks to allow for the secure exchange of health care information. The networks' main goal is to develop a statewide infrastructure to support widespread use of interoperable electronic health records and other health information technology. The networks intend to allow most, if not all, health care providers and payers in the state to securely exchange clinical information.

In all 25 states, the Medicaid agencies are working with multiple public and private entities to plan and develop statewide HIE networks. The entities typically form advisory boards or nonprofit organizations charged with overseeing development of the networks.

In 13 states, the Medicaid agencies are incorporating MITA into their HIT and HIE planning. The report says state Medicaid directors report that MITA provides useful guidance that will help modernize states' Medicaid management information systems and will lead to more efficient administration of their Medicaid programs. The directors in the 13 states also said implementing MITA will increase the interoperability of their management information systems and increase the possibility of Medicaid participation in future HIT and HIE initiatives.

Based on findings from surveying all state Medicaid programs, the Inspector General recommended that CMS: 1) continues to support MITA goals; 2) collaborates with other federal agencies and offices to assist state Medicaid agencies in developing privacy and security policies; and 3) continues to work with the Office of the National Coordinator for HIT to ensure that state Medicaid initiatives are consistent with national goals.

CMS concurred with the recommendations. The agency reported it supports the goals of the recommendations and already has taken steps to implement them.

*Download the OIG report at www.fda.gov/bbs/topics/NEWS/2007/NEW01687.html.* ■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