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# An Analysis of Medicaid Reform Concepts and Their Impact on the Health Care Safety Net

Prepared for the  
**Missouri Foundation for Health  
and the Health Care Foundation  
of Greater Kansas City**

## **Table of Contents**

<b>Forward.....</b>	<b>1</b>
<b>Glossary of Frequently Used Acronyms.....</b>	<b>2</b>
<b>Executive Summary... ..</b>	<b>3</b>
<b>Reforming Medicaid.....</b>	<b>11</b>
<b>Inventory of Key Reform Concepts .....</b>	<b>15</b>
<b>Direct and Indirect Impacts of Medicaid Reform on the Safety Net .....</b>	<b>17</b>
<b>Program Flexibility.....</b>	<b>17</b>
<b>Patient Responsibility and Empowerment .....</b>	<b>34</b>
<b>Quality Outcomes .....</b>	<b>52</b>
<b>Private Solutions Versus Public Provision.....</b>	<b>58</b>
<b>Finance Predictability.....</b>	<b>63</b>
<b>Health Information Technology: Improving Performance Through Technology ....</b>	<b>74</b>
<b>Stakeholder Perspectives on Medicaid Reform .....</b>	<b>81</b>
<b>Impact of Managed Care on the Aged, Blind, and Disabled Population: Focus on Six States.....</b>	<b>87</b>
<b>Recommendations and Conclusions .....</b>	<b>118</b>
<b>Appendix A - State Medicaid Reform and Coverage Expansions .....</b>	<b>122</b>
<b>Appendix B – Code of Federal Regulations .....</b>	<b>131</b>
<b>Appendix C - Stakeholder Perspectives on Medicaid Reform: Interview List.....</b>	<b>132</b>
<b>Appendix D - Executive Summary: 2007 Medicaid Transformation Grants .....</b>	<b>133</b>
<b>Endnotes.....</b>	<b>144</b>
<b>About Health Management Associates.....</b>	<b>149</b>

## ***FORWARD***

In the wake of the sunset of Missouri's current Medicaid program by the Missouri legislature in 2005, the Missouri Foundation for Health (MFH) and the Health Care Foundation of Greater Kansas City engaged Health Management Associates (HMA), a national health policy consulting firm, to conduct a multi-phase project examining the recent history of Medicaid in Missouri and detailing the Medicaid reform environment across the country.

The first phase of the project includes case studies that examine the four states that have used the Deficit Reduction Act (DRA) of 2005 to reform their Medicaid programs.

Phase II, the subject of the current report, is a distillation of the various Medicaid reform initiatives being proposed and undertaken in states across the nation. MFH asked HMA to focus on a series of reform options that the Foundation believed to be particularly relevant to the Medicaid reform debate anticipated in 2007 in Missouri.

A third phase entails an analysis of the impact of the Medicaid cuts enacted in 2005. Because data for 2006 are not yet available, the phase three project will emerge in the early summer of 2007.

Neither MFH nor HMA takes a position on the merit of any of the reform options. Instead, through the analyses prepared by HMA, the Foundation intends that this report and the other reports generated by the project will stimulate discussion, inform debate, and contribute to the engagement in the state's public policy process of the many Missourians with a stake in Medicaid reform.

HMA has derived thirteen fact sheets from this full report on Medicaid reform concepts. The fact sheets may be accessed on the MFH website at [www.mffh.org/policy\\_medbasics.html](http://www.mffh.org/policy_medbasics.html).

## ***Glossary of Frequently Used Acronyms***

**ABD** - Aged, Blind, and Disabled  
**BBA** - Balanced Budget Act  
**CHF** - Congestive Heart Failure  
**CMS** - Centers for Medicare and Medicaid Services  
**COPD** - Chronic Obstructive Pulmonary Disease  
**DHHS** - Department of Health and Human Services  
**DRA** - Deficit Reduction Act  
**DSH** - Disproportionate Share Hospital  
**HER** - Electronic Health Record  
**EPCCM** - Enhanced Primary Care Case Management  
**EPSDT** - Early and Periodic Screening, Diagnosis, and Treatment  
**ER** - Emergency Room  
**ESI** - Employer-Sponsored Insurance  
**FFS** - Fee-for-Service  
**FPL** - Federal Poverty Level  
**FQHCs** - Federally Qualified Health Clinics  
**HCBS** - Home and Community Based Services  
**HIFA** - Health Insurance Flexibility and Accountability  
**HIT** - Health Information Technology  
**HMA** - Health Management Associates  
**HMO** - Health Maintenance Organization  
**HAS** - Health Savings Account  
**ICFs/MR** - Intermediate Care Facilities for persons with Mental Retardation  
**IGTs** - Intergovernmental Transfers  
**LTC** - Long-Term Care  
**MAWD** - Medical Assistance for Workers with Disabilities  
**MCO** - Managed Care Organization  
**MPN** - Minority Physician Network  
**OPS** - Occupational, Physical, and Speech  
**PACE** - Program for the All-Inclusive Care for the Elderly  
**P4P** - Pay for Performance  
**PCCM** - Primary Care Case Management  
**PCP** - Primary Care Physician  
**PHA** - Personal Health Account  
**PPS** - Prospective Payment System  
**PSN** - Provider Service Network  
**RHCs** - Rural Health Clinics  
**SCHIP** - State Children's Health Insurance Program  
**SPA** - State Plan Amendment  
**SSI** - Supplemental Security Income  
**TANF** - Temporary Assistance for Needy Families  
**TWWIIA** - Ticket-to-Work and Work Incentives Improvement Act  
**UPL** - Upper Payment Limit

## **EXECUTIVE SUMMARY**

Medicaid programs have historically been administered by states under the fundamental principles set out by the federal government. In operating a Medicaid program, states must follow the basic principles of statewideness, comparability, and freedom of choice. Statewideness means that the state must offer the same benefit to everyone throughout the state. Comparability means that the same Medicaid benefits are available to all people who are eligible. Freedom of choice means enrollees must be free to obtain services from any qualified health care provider.

In addition, states must cover each service offered in the amount, scope, and duration that is considered “reasonably sufficient.” All programs must offer at least the federally mandated services and serve at least the federally mandated populations. Prior to 2006, any exceptions to the basic principles or mandatory populations could only be made with federal approval granted through the waiver process.

On February 8, 2006, the President signed the DRA which made significant changes throughout the Medicaid program. The DRA allows states to enact program changes without having to adhere to the fundamental principles of Medicaid including state-wideness and comparability.

That is, using DRA authority, states can:

- vary Medicaid benefits for state defined groups of recipients without providing comparable benefits for all recipients,
- provide defined benefits for recipients in specific geographic locations without providing access statewide, and/or
- make these changes to their Medicaid program using a state plan amendment (SPA) as opposed to the lengthy waiver process.

The DRA is the latest vehicle for Medicaid change and has prompted much of the Medicaid reform discussion currently happening throughout the nation.

In addition to the DRA, states have been exploring both Medicaid and broader health care reform initiatives in response to growing concern about the rising cost of health care, the percentage of the state budget spent on health care, and the persistence of high rates of people without health insurance. State proposals have varied from those that are broad in scope (e.g., Massachusetts and California where Medicaid reform and initiatives to reduce the numbers of the uninsured have been tied together) to DRA-specific proposals in West Virginia, Idaho, and Kentucky (additional

information on these states appears in “Key Medicaid Reform Elements in States Adopting DRA State Plan Amendments: Idaho, Kansas, Kentucky, and West Virginia,” which is slated for publication in May 2007. For states undertaking comprehensive Medicaid reform initiatives, the federal government still requires waivers to be submitted for elements not covered by the DRA, such as new financing arrangements. States are currently exploring a wide range of approaches, which are all grounded in several key reform concepts.

## **Medicaid Reform Concepts and the Safety Net**

The safety net is generally understood to include public and not-for-profit hospitals as well as free community clinics and federally qualified health centers (FQHCs) that provide the majority of the health care services used by those without health insurance or some other means to pay for the cost of their care.

These same safety net entities in communities across Missouri rely heavily on Medicaid reimbursement and special financing to help offset the cost of providing this otherwise uncompensated care for the uninsured. Consequently, their ability to serve the needs of communities is inextricably linked to Medicaid. Perennial changes to Medicaid affect the safety net. Medicaid reform will do the same and has the potential to do so on a larger scale, depending on how reform is approached.

As Missouri considers reform initiatives, it will be helpful to understand these reform concepts and their impact on the safety net. This study will examine key concepts used by states in pursuing Medicaid reform, including:

- Program Flexibility
  - Benefit Package Flexibility
  - Medicaid Ticket-to-Work/Buy-In
  - DRA Buy-In
  
- Patient Responsibility/Empowerment and Consumer Involvement
  - Cost-Sharing
  - Informed Choice
    - Consumer Driven Health Care
    - Client-Centered Planning
    - Transparency
  - Rewards/Penalties for Health/Unhealthy Behaviors
    - Member Agreements
    - Enhanced Benefit Accounts

- Quality Outcomes
  - Service Integration
  - Pay for Performance (P4P)
  - Provider Outcomes
  - Disease/Chronic Care Management
- Private Solutions Versus Public Provision
  - Long-Term Care (LTC) Partnership Plans
- Finance Predictability
  - Revenue Preservation
  - Managed Care Expansion
- Health Information Technology (HIT)
  - e-Applications
  - 2-1-1
  - e-Prescribing

## **Stakeholder Perspectives on Medicaid Reform**

As a part of this review of the potential impact of Medicaid reform on safety net providers, HMA conducted interviews with Missouri safety net providers or their representatives in an attempt to document their perspectives on common Medicaid reform concepts, such as managed care expansion, tailored benefit packages, enhanced consumer involvement, and healthy behavior incentives. The goal was to document broad perspectives, as opposed to specific critiques, on how these concepts might impact the safety net.

This series of interviews was limited in scope and size and clearly does not offer a large enough sample to be considered a definitive survey of safety net providers. Rather, the information gleaned from these interviews provides some general observations about the Missouri safety net's viability and how Medicaid reform concepts potentially affect that viability.

## **Impact of Managed Care on the Aged, Blind, and Disabled Population**

Medicaid managed care models for the aged, blind, and disabled (ABD) populations are as unique in each state as are each state's Medicaid programs. Broadly defined, states are implementing fully capitated programs with public and private Health Maintenance Organizations (HMOs) and/or non-capitated primary care case management (PCCM) systems. Within those two broad categories there are multiple variations of each model depending on the state's Medicaid program structure, political interests, and managed care program goals.

This report examines Medicaid managed care models in six states: Arizona, Florida, Minnesota, North Carolina, Texas, and Wisconsin. Variations exist among the models implemented by these states, including target populations, the benefits included in the capitation program, and whether enrollment is mandatory or voluntary. For each model, performance indicators and special quality studies conducted by states to measure the outcomes of the programs were examined. The performance indicators and quality studies included in this review were chosen because they provide information about how the various models have affected both traditional safety net providers and Medicaid enrollees.

***Key Factors Related to Cost, Quality, Satisfaction, and Access***

As states look to enroll all or part of their ABD populations into managed care, questions arise as to whether these efforts are successful and which design elements contribute to their success. Several key indicators related to access, quality, satisfaction, and cost were identified and are key to understanding the success of the models of Medicaid managed care that have been implemented in other states. Additionally these indicators can help inform how the various models have impacted enrollees and safety net providers. The indicators include:

- Access to services/choice of providers,
- Access to home and community based services,
- Disease management/health outcomes,
- Use of preventive care,
- Personal outcome measures,
- Consumer satisfaction,
- Provider satisfaction,
- Inpatient hospitalization rates,
- Emergency room (ER) utilization rates, and
- Prevention of institutionalization.

While not all of the six states reviewed addressed every indicator, this report includes information on these key factors where it is available.

***Recommendations for a Baseline of Key Indicators for Assessing Impact of Medicaid Managed Care Expansion***

When states are considering the adoption of Medicaid managed care programs for the ABD population, it is important and challenging to determine the appropriate means to track the impact

of these programs. In the states reviewed, sometimes goals and measures were put in place pre-implementation and sometimes post-implementation. Often times what is measured and how it is measured changes over time making longitudinal studies on the impact of a specific managed care initiative more difficult to conduct.

Depending on the goals established for the program, the target population(s), and the type of managed care initiative, the state should develop a set of indicators specific to the goals of the initiative. The process for establishing the goals and indicators, particularly for a program targeting the elderly and people with disabilities, should involve stakeholders such as advocacy groups, Medicaid beneficiaries, providers, and health plan representatives. Planning on the front end takes time, but will better prepare the state, beneficiaries, and stakeholders for program implementation.

Without a clear understanding of the covered population, benefit package, service area, and program goals it would not be prudent to offer recommendations on performance indicators. However, the report includes some examples of indicators commonly used in other states or identified in the Report on the Health Care Safety Net in Missouri that might provide a starting point for the discussion of measuring the impact of managed care expansion.

## **Issues in Implementation of Reform Concepts**

As states pursue the many programmatic and financing options now available to reform their Medicaid programs, it will be important to understand both the direct and indirect impact on consumers of services and on safety net providers. This report addresses critical issues that should be monitored as any reform proposal is debated.

### ***Program Flexibility***

- It will be important to determine whether the benefit flexibility provisions in the DRA present an opportunity for Missouri to restore any eligibility cuts made in 2005.
- In the event that Missouri decides to use DRA benefit flexibility, it will be important to enforce the DRA provision requiring that states ensure that individuals have access to FQHCs and Rural Health Clinic (RHC) services and that reimbursement for services provided in these locations meets federal requirements.
- Care must be taken to guard against viewing certain benefits (e.g., dental or mental health) as non-essential, understanding that their absence can lead to increased use of services such as physician visits or hospital care.

### **Cost-Sharing**

- There are a variety of ways in which cost-sharing strategies may have negative impacts on the safety net. For example:
  - If increased premiums discourage enrollment of eligible people or lead to increases in disenrollment, then safety net providers will not see a decrease or will see an increase in uninsured patients, particularly in hospital ERs.
  - If increased point-of-service cost-sharing discourages beneficiaries from seeking early or preventative care or foregoing important treatments such as filling a prescription, then safety net providers are likely to see increases in patients seeking care later and with higher acuity than otherwise would have been the case.
  - It is typically hard to collect co-payments from Medicaid beneficiaries, and many safety net providers are required to deliver services (even when a patient cannot or will not pay) unless the state exercises its option under the DRA to allow providers to deny services.
  - Safety net providers may face a diversion of clinic resources toward finding alternative resources for patients who lose their Medicaid coverage due to higher premiums or strict enforcement of premium payment policies.
  - Safety net providers may experience an increased risk of no-show rates, patients not coming back for follow up visits, and/or not having prescriptions filled because of inability to afford co-payments.
  
- It will be important for the state to exercise care in designing cost-sharing strategies to minimize the negative impacts on the safety net. The following should be considered:
  - What services should be exempt from cost-sharing altogether?
  - What eligibility groups should be exempt from cost-sharing?
  - What is the appropriate balance between premiums and point-of service cost-sharing?
  - What is an appropriate cap on total out-of-pocket expenditures?
  - How can the state most effectively educate beneficiaries so that they understand the cost-sharing policies and seek appropriate care?

### **Healthy Behavior Incentives**

- Effective incentives to reward desired behaviors, particularly those that promote disease management and wellness strategies, can have a positive effect on the safety net by decreasing inappropriate use of emergency facilities and potentially involving safety net providers as partners in disease management initiatives.
  
- There are potential unintended consequences of healthy behavior incentives. To be effective, incentives need to be powerful enough to change behavior. At the same time, unintended consequence can result when basic health care services are conditioned upon certain behaviors. For example:
  - To the extent that beneficiaries are unwilling or unable to comply with their agreements and therefore lose some of their Medicaid benefits, providers could see increased ER utilization or increased acuity of conditions for inpatient admissions, particularly where there is a lack of follow up care or insufficient management of chronic health conditions that could have serious health consequences.
  - To the extent that beneficiaries are unwilling or unable to comply with their agreements and therefore lose some of their Medicaid benefits, providers could see increased reliance on safety net providers as a source of care for services that would no longer be reimbursed by Medicaid.

- If medical practitioners are required to monitor and report patient compliance with the healthy behavior agreement, providers face an increased administrative burden for Medicaid patients. This responsibility could also lead to practitioners playing the conflicting roles of both patient advocate and enforcer.
- To the extent that provider participation in Medicaid already is tenuous, the administrative burden associated with monitoring and reporting patient compliance may lead some providers to leave the program or shift any unreimbursed costs associated with the activity to private pay patients.

### ***LTC Partnership Programs***

- While developing LTC insurance strategies may be important, the impact of these initiatives will be felt gradually, since LTC insurance is typically purchased several years in advance of needing the benefit. LTC insurance is not an option for the elderly and people with disabilities who are currently in need of or at-risk for institutionalization. Any speculation about the impact of this strategy should be viewed with caution.

### ***Federal Caps and Restrictions on Safety Net Funding***

- It is likely that the Centers for Medicare and Medicaid Services (CMS) will require limits on Missouri's current Medicaid financing strategies and payment methodologies (e.g., disproportionate share hospital payments (DSH) and upper payment limit (UPL) funding) in exchange for federal approval of the state's Medicaid reform plan.

### ***Medicaid Managed Care and Revenue Preservation Strategies***

- Implementation or expansion of capitated Medicaid managed care will impact revenue preservation strategies such as UPL funding unless the two can be preserved as part of a Medicaid reform waiver. It will be important to consider these impacts when looking at the overall cost picture. Some states have been successful in proposing new uses for funds that had been available to support the safety net.
- Expanding managed care, either to new geographic areas or new populations, may present challenges for safety net providers. Safety net providers need to be poised to contract with Managed Care Organizations (MCOs) so that they can become part of managed care provider networks.
- Care must be taken that any expansion of managed care to the elderly or people with disabilities is accompanied by enforceable requirements that participating MCOs have the necessary expertise and knowledge to competently serve them.
- It will be important to ensure that managed care is designed and implemented in a way that emphasizes prevention, acts as a vehicle for developing improved strategies for treating and managing chronic diseases, and improves access to specialty providers such as mental health practitioners.

## **Plain Talk About Launching Medicaid Reform Initiatives**

As Missouri considers Medicaid reform initiatives, whether focused on encouraging healthy behavior, or implementing managed care expansion to the ABD population, this report includes some general guidelines that will help to ensure the success of Missouri's efforts.

- Establish a public process for implementation.
- Include strategies to address the varying concerns of stakeholders.
- Develop a comprehensive implementation strategy.
- Establish realistic timelines.
- Dedicate resources – financial and human – to the implementation task.
- Develop an implementation strategy as part of the implementation plan.
- Establish a baseline for evaluation of reform.
- Develop contract management expertise and capacity.

## **REFORMING MEDICAID**

Medicaid programs have historically been administered by states under the fundamental principles set out by the federal government. In operating a Medicaid program, states must follow the basic principles of state-wideness, comparability, and freedom of choice. In addition, states must cover each service offered in the amount, scope and duration that is considered “reasonably sufficient.” All programs must offer at least the federally mandated services and serve at least the federally mandated populations. Prior to 2006, any exceptions to the basic principles or mandatory populations could only occur through the waiver process.

On February 8, 2006, the President signed the DRA which made significant changes throughout the Medicaid program. The DRA also allows states to enact program changes without having to adhere to the fundamental principles of the Medicaid entitlement including state-wideness and comparability. In addition, states are not subject to the onerous budget neutrality calculations required for a waiver approval. The DRA has served as a new vehicle for change and has prompted much of the Medicaid reform discussion happening today.

In addition to the DRA, states have been exploring both Medicaid and broader health care reform initiatives in response to growing concern about the rising cost of health care and the percentage of the state budget spent on health care. For states undertaking comprehensive Medicaid reform initiatives, the federal government still requires waivers to be submitted for elements not covered under the DRA, such as new financing arrangements. As Missouri considers reform initiatives, it will be helpful to understand these reform concepts and their impact on the safety net.

There are several strategies used by states to develop creative alternatives to the standard Medicaid program. Table 1 identifies the common types of Medicaid waivers and their uses.

### **Reform Concepts**

Summarized below is a brief description of key concepts used by states in pursuing Medicaid reform, all of which are discussed in greater detail throughout the report.

#### ***Program Flexibility***

- *Benefit Package Flexibility*: the ability provided by the DRA to limit or tailor benefits for discrete populations (e.g., healthy families, persons with disabilities, persons with chronic illnesses), compared to traditional Medicaid which requires a comprehensive set of benefits for all enrollees.

- *Medicaid Ticket-to-Work/Buy-In*: a Medicaid eligibility category which states can create to provide coverage to people with disabilities who work and require them to pay a share of the cost of their care in the form of co-payments and/or premiums.
- *DRA Buy-in*: the DRA option that allows children with severe disabilities in households with income up to 300 percent of the federal poverty level (FPL) to buy-in to Medicaid coverage. In order for a family to participate, a state must require the parent to take employer-sponsored insurance (ESI), if available, and the employer must contribute at least 50 percent of the total premium cost. If such coverage is purchased by the family, then the state must reduce the premium for the Medicaid buy-in by an amount commensurate with the parent’s premium contribution for the employer coverage.

<b>Type of Waiver</b>	<b>Description</b>
Section 1115 Research and Demonstration	Allows flexibility for states to test substantively new ideas for operating their Medicaid programs (e.g., states can use these waivers to develop statewide system reforms and extend certain services to certain low-income populations).
Section 1915(b) Freedom of Choice	Allows states to waive state-wideness, comparability of services, and freedom of choice (e.g., states can use these waivers to mandate enrollment into managed care, mandate use of a central broker to assist in making healthcare choices, or limit choice of providers).
Section 1915(c) Home and Community Based Services (HCBS)	Allows states to provide HCBS to people who meet eligibility requirements for institutional care such as nursing homes, intermediate care facilities for persons with mental retardation (ICFs/MR), or hospitals (e.g., development of community based alternatives to institutional care or providing services that are not otherwise authorized by the state Medicaid plan but that support the individual’s ability to live in the community).

***Patient Responsibility/Empowerment and Consumer Involvement***

- *Cost-Sharing*: an enrollee’s contribution to the cost of health care. In Medicaid this is usually in the form of modest payments made directly to the provider when accessing care or monthly premiums paid to the program or its contractors. While cost-sharing has been limited under traditional Medicaid, it has been allowed to a greater degree in the State Children’s Health Insurance Program (SCHIP) and now can be used somewhat more broadly in Medicaid as a result of the DRA. Cost-sharing amounts are usually based on income and/or type of service received.

- *Informed Choice:*
  - Consumer Driven Health Care: a health benefit design where consumers have:
    - a high deductible insurance plan,
    - a personal account funded in various ways to pay a portion of the cost-sharing contributions required to access care,
    - a gap between the annual amount available in the account and the beginning of coverage under the high deductible plan, and
    - an internet-based support system.<sup>2</sup>
  - Client-Centered Planning: focuses on Medicaid enrollees with developmental disabilities and ties in to programs which provide HCBS.
  - Transparency: collecting and reporting cost and quality data in a format that can be accessed by the public and intended to improve the delivery of services and ultimately improve the cost-efficiency of the system as a whole.
- *Rewards/Penalties for Healthy/Unhealthy Behaviors:*
  - Member Agreements: usually written statements signed by enrollees who thereby commit themselves to appropriate and timely accessing of the health care system as well as demonstrating healthy behaviors.
  - Enhanced Benefit Accounts: enrollee accounts into which rewards for healthy behaviors (in the form of credits or funds) are deposited and which recipients may use to purchase services or items not typically covered under the Medicaid program.

### **Quality Outcomes**

- *Service Integration*: bringing different Medicaid-funded health services (e.g., physical and behavioral health care) together in a coordinated, client-centered framework to improve client services and satisfaction.<sup>3</sup>
- *P4P*: the use of provider payment methods and other incentives to encourage quality improvement and patient-focused, high-value care.<sup>4</sup>
- *Provider Outcomes*: the measurement and assessment of provider performance in relation to established standards; often associated with transparency and P4P.
- *Disease/Chronic Care Management*: care coordination focused on specific chronic disease conditions (e.g., diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF)) and utilizing strategies such as patient education and patient self-management.

### **Private Solutions Versus Public Provision**

- *LTC Partnership Plans*: partnership between Medicaid and LTC insurers to provide protection for patients against impoverishment from the costs of LTC. Purchasers are insured for LTC up to a pre-set dollar level through the private insurer. Once the private insurance is exhausted, beneficiaries can continue to receive LTC under Medicaid without spending down their assets. Additionally, these plans exempt protected assets from Medicaid estate recovery requirements.<sup>5</sup>

### **Finance Predictability**

- *Revenue Preservation*: strategies to preserve the level of federal Medicaid funding coming to the state as the federal government tries to further restrict UPL payments, DSH payments, and intergovernmental transfers (IGTs) used to identify local public funds as state matching funds.
- *Managed Care Expansions*: models of service delivery involving monthly payments to HMOs in exchange for which the HMOs assume full-risk that those payments will be sufficient to cover medical care and administrative costs. Other models include partial risk payments to health plans or PCCM approaches in which payments are made to primary care physicians (PCP) in the form of a care coordination fee.

### **Health Information Technology**

- *e-Applications*: online methods of completing and submitting applications for enrollment in publicly financed health care programs.
- *2-1-1*: a system for integrating local information, referral phone numbers, and operations into a single, easy-to-remember number. The system allows individuals to access a call center to connect them to health and human services available in their community.\*
- *e-Prescribing*: use of web-based technology for the submittal and filling of prescriptions along with the medication management tools to support those activities.

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\* MFH and United Way of Greater St. Louis have committed \$8.5 million to bring the 2-1-1 helpline service to all Missourians. The service will roll out in three phases, with the initial phase beginning in the summer of 2007. 2-1-1 connects people to needed health and human service organizations and volunteer opportunities in their communities, offering 24-hour, seven-days-a-week service to callers. Missouri becomes the 20th state to have 2-1-1 coverage available to the entire population.

## **INVENTORY OF KEY REFORM CONCEPTS**

As states have undertaken comprehensive Medicaid reform initiatives, their work has been defined by a series of conceptual elements that have guided their efforts. As Missouri considers reform initiatives, it will be helpful to understand these reform concepts and their impact on the safety net.

The process of identification and analysis of health care and Medicaid reform concepts was facilitated by the creation of an inventory of key reform strategies. These concepts are being implemented or considered for implementation in states throughout the nation using Medicaid waivers or SPAs authorized under the DRA.

Appendix A contains a summary of key reform and Medicaid expansion proposals in 27 states. As Appendix A shows, many different approaches to reform are underway or in the planning stages. These states are using, or contemplating the use of, a variety of mechanisms, including SPAs, provisions of the DRA, or section 1115 or 1915 waivers. Most are in the early stages of development or implementation, limiting the availability of outcome data. These initiatives are grounded in a range of reform concepts that drive states' efforts.

This inventory was then used to identify the range of reform concepts being addressed in state reform initiatives and a comprehensive list of Medicaid reform concepts was established. In consultation with MFH staff, a list of key reform concepts was identified for in-depth review based on their potential for having direct and indirect impacts on elements of Missouri's safety net. Table 2 outlines the key reform concepts discussed in this paper.

**Table 2. Medicaid Reform Concepts**

**Program Flexibility**

- New options for benefit packages such as limiting or tailoring benefits for discrete populations (e.g., healthy families, persons with disabilities, and persons with chronic illnesses)
- Strategies to expand participation, such as Medicaid Ticket-to-Work and DRA buy-in programs

**Patient Responsibility/Empowerment and Consumer Involvement**

- Cost-sharing strategies (e.g., increasing the number of services for which co-payments apply, DRA non-preferred pharmacy and ER non-emergency services options, and premiums for higher income groups)
- Informed Choice initiatives such as:
  - Consumer driven health care,
  - Client-centered planning, and
  - Increased transparency of health care costs and quality for consumers and providers
- Rewards/penalties for healthy/unhealthy behaviors, including member agreements and enhanced benefit accounts
- New options for benefit packages

**Quality Outcomes**

A variety of strategies and pilot programs designed to focus on improving health outcomes, including:

- Service integration: behavioral and physical health,
- P4P,
- Provider outcomes: measures, assessment and transparency,
- Chronic disease management/chronic care management,
- Targeted case management, and
- Best practices: development, education, integration

**Commercial/Private Solutions Versus Public Provision**

- Medicaid linkage with commercial/private resources (e.g., LTC Partnership Plans and other private financing arrangements for LTC)

**Finance Predictability**

- Revenue preservation strategies, including Federal caps and restrictions on safety net funding (e.g., UPL, DSH, and IGTs)
- Managed care strategies, such as mandatory managed care, expanded managed care, full and partial capitation (including risk-based) into new geographical areas (e.g., rural) and for new eligibility groups (e.g., ABD, foster care, and special needs), and enhanced primary care case management (EPCCM)

**HIT**

- Technology to increase access: e-applications for real-time eligibility determination

## **DIRECT AND INDIRECT IMPACTS OF MEDICAID REFORM ON THE SAFETY NET**

The following sections include descriptions of each of the Medicaid reform concepts, examples from states in which they have been implemented, and identification of direct and indirect impacts of these concepts. Issues for policymakers to consider have also been identified that may be helpful as Missouri pursues Medicaid reform based on one or more of these concepts.

### **Program Flexibility**

The DRA provides unprecedented flexibility for states to design alternative benefit packages for the Medicaid population without going through the extensive process involved in obtaining a waiver. General benefit flexibility under Section 6044 of the DRA means that states are no longer constrained by federal statewideness and comparability requirements. As a result of the DRA:

- States can vary Medicaid benefits for different groups of Medicaid recipients, such as children or the elderly, or for recipients in different geographic locations in the state.
- States can develop these benefit packages by the relatively simple process of amending their state Medicaid plan, allowing them to by-pass the federal waiver process.

The specific parameters of this flexibility are described below.

#### ***DRA Benefit Flexibility Enrollment Restrictions***

The DRA alternative benefit flexibility can only apply to a state's eligible categories that were in existence under the state's Medicaid plan on or prior to enactment of the DRA. Therefore, alternative benefit packages presumably cannot be used for coverage expansions implemented after February 8, 2006 and the provisions cannot be used as a tool to expand coverage to the uninsured.

The DRA prohibits states from requiring mandatory enrollment into alternative benefit plans for certain Medicaid eligibility groups. However, states can allow individuals in these "exempt" groups to enroll at the individual's option. In addition, CMS has taken the position that a state can automatically enroll exempt individuals into an alternative benefit plan as long as they allow them to "opt-out" back into the standard Medicaid benefit structure. The following table lists those Medicaid populations that states may or may not require to enroll in an alternative benefit plan.

**Table 3. DRA Alternative Benefit Enrollment: Options for States**

Populations a State May Not Require to Enroll (Exempt Populations)	Populations for Which the State May Choose Mandatory or Optional Enrollment
<ul style="list-style-type: none"> <li>• Mandatory pregnant women (up to 133% of FPL)</li> <li>• Blind and disabled</li> <li>• Terminally ill in hospice</li> <li>• Institutionalized (inpatient, nursing facility, or ICF/MR)</li> <li>• Medically frail and special health care needs (as defined by the Secretary of the Department of Health and Human Services* (DHHS))</li> <li>• Child welfare, foster care, or adoption assistance recipient children</li> <li>• Temporary Assistance for Needy Families (TANF) recipients</li> <li>• Women in the Breast and Cervical Cancer Treatment Program</li> <li>• Limited service beneficiaries (medically needy and spend-down)</li> </ul>	<ul style="list-style-type: none"> <li>• Optional pregnant women (up to 185% of FPL)</li> <li>• Categorically needy children</li> <li>• Optional children expansions</li> <li>• Low-income adults who do not receive TANF or Supplemental Security Income (SSI), and who do not fall within exempt classifications.</li> </ul>

\* Medically frail include those dually eligible for Medicare and Medicaid, certain children under age 19 eligible for SSI, TEFRA children (children who meet the SSI disability standard receiving medical care at home, but who would be eligible for Medicaid if they were in an institution), children receiving Title V, Section 501(a)(1)(D) Children with Special Health Care Needs)

**DRA Benchmark Coverage**

The DRA specifies benchmark benefit coverage that a state can offer as an alternative to the state’s standard Medicaid benefits. The state can also choose to establish a benefit package that is actuarially equivalent to one of the benchmark benefit packages, or offer a set of benefits that has been approved by the federal Secretary of DHHS, known as Secretary-approved coverage. The specific benchmark or benchmark equivalent coverage defined in the DRA mirror those in federal SCHIP legislation (see Table 4). Thus, states may find the DRA provisions an attractive way to pool healthy children and adults in the Medicaid and SCHIP programs under a single benefit plan. The DRA requires states to provide wrap-around Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under the age of 19. States also have the option to use other types of wrap-around benefits and specify targeted populations to a restricted benefit or set of benefits. This allows states to tailor their benefit structure to meet the specific needs for select populations and also provides a mechanism to create enrollment incentives for those populations exempt from mandatory enrollment, such as the aged or disabled.

**Table 4. DRA Benchmark Coverage Or Benchmark Equivalent Coverage**

- Federal Employee Health Benefit Plan (the standard Blue Cross Blue Shield preferred provider options service benefit plan)
- The state's employee coverage plan
- Coverage offered through an HMO with the largest insured commercial non-Medicaid enrollment in the state
- Other coverage which the Secretary of DHHS approves

If a state opts to use benchmark-equivalent coverage, then certain basic services must be included<sup>6</sup> and the state is required to demonstrate that the coverage provides at least 75 percent of the actuarial value for pharmacy, mental health, vision, and hearing services as that provided in the benchmark benefit. In addition, states are required to assure that enrollees have access to RHCs and FQHCs, and that these safety net providers are paid through existing federal statutory Prospective Payment System (PPS) mechanisms.

### **State Implementation of DRA Benefit Provisions**

If a purpose of the DRA was to promote innovation, then early evidence suggests it is succeeding. Although only a few states have applied for and received SPAs under the new DRA provisions, each has adopted very different approaches to meet their state's specific needs. Currently, four states have applied for and received approval of SPAs to offer alternative benefits under the DRA authority: Idaho, Kansas, Kentucky, and West Virginia.

#### **IDAHO**

Idaho received CMS approval for three alternative benefit plans on May 25, 2006:

- the Basic Plan for healthy adults and children;
- the Enhanced Plan targeting the disabled and individuals with special health care needs; and
- the Coordinated Plan for individuals dually eligible for Medicare and Medicaid.

All three plans are identified as Secretary-approved coverage for alternative benchmark plans. Because all three plans target populations that are exempt from mandatory enrollment, they are all an optional enrollment choice to Idaho's standard Medicaid benefit. However, Idaho has taken several steps to "encourage" enrollment into the various plans:

- Idaho enrolls individuals into the appropriate optional plan after conducting a health assessment. Individuals must then "opt-out" if they prefer to receive the standard

Medicaid benefits. Thus enrollees must take action to retain standard Medicaid. Individuals are not initially enrolled into the standard Medicaid benefit.

- Idaho has added additional benefits to each alternative benefit plan that would be attractive to the targeted populations.
- Idaho has applied for an SPA that would scale back the standard Medicaid benefit, essentially eliminating optional benefits under federal regulation, such as pharmacy, therapies, dental services, vision services, and certain prevention and wellness benefits.<sup>7</sup>

While CMS has not yet approved this third initiative, it raises some interesting questions about the extent of state flexibility, the nature of “voluntary” enrollment, and the intent of the DRA legislation with respect to protection of vulnerable populations. While Idaho’s Enhanced Plan (as it is currently structured) provides all the benefits covered under the state’s standard Medicaid benefit (prior to the pending scaled back design), Congress’s intent to protect vulnerable populations from possible negative impacts of state coverage decisions under the flexibility provisions (not only what benefits are offered but who may access them) by making enrollment optional, is seemingly compromised if the choice is between the “optional” alternative benefit and a significantly diminished Medicaid benefit.

Other than those proposed for the standard Medicaid benefit, new benefit restrictions and limitations apply only to the Basic Plan. The Basic Plan does not include LTC benefits and applies significant limits to mental health services. In addition, some provider specialties (e.g., rehab mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health, and personal care case management) are limited to diagnostic and evaluation services only under the Basic Plan. On the other hand, the state added a wellness exam benefit for adults and established school-based preventative and wellness services for children.

The state conducts a health risk assessment during initial enrollment (and at renewal) to determine placement into a plan. However, if at any time a medical evaluation determines an individual’s health needs have changed, the individual can transition from one plan to another.

EPSDT benefits are preserved for children within both the Basic and Enhanced Plans. Services required as a result of an EPSDT screen are not subject to the service limitations in either plan but do require prior authorization if limits are exceeded. Children that are found to have special health care needs receive those benefits through either the Enhanced Plan or as “wrap-around

services to benefits covered under the State Plan for children who do not opt-in to an Enhanced Benchmark Benefit Package.”

The Basic Plan also includes a Personal Health Account (PHA) component that targets individuals who use tobacco or who are obese. The state plans to issue vouchers to “targeted individuals” who have “earned” credits which may be used to purchase goods and services related to tobacco cessation and weight loss (e.g., nicotine replacement therapies, fitness program memberships, and bicycle helmets are noted in the SPA). Additional credits can be earned through complying with recommended preventive services and can also be used to pay premiums where families are subject to premium payments. Although CMS approved benefits under the Coordinated Plan, the state indicates that this benefit is still under development. Idaho has proposed to integrate Medicaid and Medicare benefits through enrollment into Medicare Advantage (i.e., managed care plans serving Medicare recipients).

#### KANSAS

Kansas received CMS approval for an SPA on September 7, 2006 which established an alternative benefit package called Working Healthy. The goal of the program is to offer an alternative benefit package without regard to comparability of services. The state is offering a very specific additional set of benefits to only a small portion of the Medicaid population (thus Medicaid services are not “comparable” across all Medicaid enrollees).

The Working Healthy program targets people with disabilities who are in the basic buy-in population of the state’s Ticket-to-Work and Work Incentives Improvement Act (TWWIIA) program. These include working individuals with developmental or physical disabilities, or traumatic brain injury, who are between the ages of 15 and 65 and who, except for income and resource levels, are eligible to receive SSI. They can have countable net income no higher than 300 percent of FPL (\$30,630 for an individual) and no more than \$15,000 in assets.

Enrollment is optional and members receive the state’s Medicaid benefits plus a set of benefits to assist them to become more independent, including:

- Personal assistance services, such as with activities of daily living;
- Independent living counseling, such as information and training to direct and manage their personal assistance services and budgets;

- Assistive services, such as items or equipment that improves independence, employment, or health and safety.

Individuals may self-direct their care and manage their budgets, or may choose a representative to direct care and have a fiscal management service to manage funds on their behalf.

## KENTUCKY

CMS approved several SPAs related to Kentucky's Health Choices Medicaid reform plan on May 3, 2006. Among other initiatives, the amendments establish copayments and benefit service limits for Global Choices (i.e., the state's standard Medicaid benefit) and establish three alternative benefit packages (including copays and benefit limitations) plus a fourth Medicaid opt out alternative benefit:

- Comprehensive Choices (targets the elderly and disabled that meet nursing facility or institutional level of care);
- Family Choices (targets Medicaid and SCHIP children);
- Optimum Choices (targets individuals who meet the ICF/MR or developmental disability level of care); and
- Premium Assistance for ESI, available to any enrollee with access to insurance through their employer.

The three alternative plans are described as Secretary-approved benchmark plans. According to the SPAs, benefit limits in all four plans (Medicaid and alternative plans), and monetary limits on hearing aids and eyeglasses, are "soft" limits and may be overridden when medical necessity is established. Exceptions exist for those benefits that are associated with age.<sup>8</sup> The complexity of this medical necessity override process will dictate to what degree the benefit restrictions pose significant issues for beneficiaries. The SPAs establishing the benefit packages address medical services only, leaving LTC to be dealt with separately.

Global Choices is Kentucky's "default" standard Medicaid benefit. Individuals who remain covered under standard Medicaid are all mandatory populations, optional spend down populations, pregnant women, and the aged and disabled who do not meet nursing facility level of care. Also, individuals who do not choose to enroll in the optional alternative benefit plans receive Global Choice benefits.

Kentucky established new service limitations and increased co-payments for services within Global Choices.<sup>9</sup> The state applied limits to such services as chiropractic (15 visits annually for

adults and 7 per year for recipients under 21 years of age); hearing and vision services (eliminated for adults and for children, limited to one annual hearing evaluation, one pair of eyeglasses, and limited follow-up visits for hearing aids); home health services; and occupational, physical, and speech (OPS) therapies (annual number of visits limited).

Family Choices is the alternative benefit package for children (except those eligible through Title IV Part A -AFDC/TANF, and E-Foster Care and Adoption Assistance, who are served under Global Choices) in Medicaid and Kentucky's Children's Health Insurance Program (KCHIP). Enrollment in Family Choices is mandatory. The benefit limits vary for Medicaid eligible children, including KCHIP Medicaid expansion children, and KCHIP separate program children. The KCHIP separate program children are not covered for non-emergency medical transportation, treatment services per EPSDT, or substance abuse services. The benefit has more generous vision services than Global Choices and more restrictive home health benefits.

Comprehensive Choices and Optimum Choices are the alternative benefit packages for institutional level of care individuals, including those that receive waiver services. Some benefits are subject to limits, but co-payments under this plan are generally lower than those for Global Choices. Enrollment into these plans is optional and beneficiaries may choose to receive services under Global Choices.

Other than LTC services, the major difference between Global Choices and the three alternative benefit packages (i.e., Family, Comprehensive, and Optimum Choices) lies in a small set of benefits and utilization limits (Table 5). Family Choices is the only benchmark plan with mandatory enrollment. Comprehensive and Optimum Choices serve populations the DRA exempts from mandatory enrollment, and therefore have optional enrollment. However, beneficiaries will likely find these options attractive because of potentially lower out-of-pocket expenses due to lower cost-sharing requirements and less restrictive limits on some benefits.<sup>10</sup>

	<b>Global Choices</b>	<b>Family Choices</b>	<b>Comprehensive Choices</b>	<b>Optimum Choices</b>	<b>ESI</b>
<b>Benefits Subject to Service Limits</b>	Home health, OPS therapies, audiometric, chiropractic, and dental  All benefit service limits are “soft” and may be overridden if medically necessary through a prior authorization process.	Same as Global but with more restrictive limits on home health services, and less restrictive limits on vision services.  EPSDT services apply to Medicaid recipients.	Same as Global but with less restrictive limits on OPS therapies.	Same as Global but with less restrictive limits on OPS therapies	Subject to plan benefit limits – No Medicaid wrap around.

Kentucky also uses ESI as a novel approach to expanding access by establishing this type of insurance as an alternative benchmark-equivalent benefit package through an SPA. The option is available to any recipient except children, who are entirely excluded. ESI benefits will be benchmarked to the Kentucky State Employee Essential Health Insurance Plan and the state will not provide any wrap around services. Individuals that opt for ESI may opt out at any time and revert back to Medicaid coverage.<sup>11</sup> ESI recipients will receive premium assistance but will be subject to service limitations and cost-sharing imposed by the employer’s plan.

Individuals who wish to receive ESI benefits submit their request along with the schedule of benefits under the plan and the state determines whether plan benefits are equivalent to the benchmark plan, and whether the plan “is cost effective and meets economy and efficiency principles.” If the plan fails to meet these criteria, the ESI request will be denied.

**WEST VIRGINIA**

On May 3, 2006, West Virginia became one of the first states in the nation to receive CMS approval for an SPA implementing an alternative Medicaid benefit package under the DRA. West Virginia’s benefit structure is designed to influence the behavior of its Medicaid population by offering enhanced benefits for members that agree to and comply with certain expectations about responsible utilization of health care services.

West Virginia’s SPA provides that the alternative benefit package generally applies to “healthy adults and healthy children on Medicaid.” The medically needy and other individuals that “spend

down” to eligibility are explicitly excluded, as are the other exempt population groups defined in the DRA.<sup>12</sup>

The alternative benefit package under West Virginia’s SPA provides an “Enhanced” benefit package for beneficiaries that sign and conform to a Medicaid member agreement and a scaled-back, or “Basic” benefit package for those who fail to sign the agreement or do not fulfill their obligations under the agreement. The Medicaid member agreement lists 12 member responsibilities, including keeping and being on time for appointments with providers, using the patient’s medical home for well visits and when ill (rather than the ER), taking prescribed medications, and following health improvement programs as directed by the medical home. The member agreement is discussed in detail later in this document in the section devoted to patient responsibility and empowerment.

Members who sign and comply with the member agreement gain access to the Enhanced Benefit Plan which includes all the services under the Basic Plan (which includes all Medicaid mandatory benefits), as well as the following additional services available to both adults and children:

- Weight management services,
- Chiropractic services,
- Podiatry services, and
- Nutritional education.

Adults in the Enhanced Plan have access to the following additional services:

- Inpatient psychiatric services,
- Tobacco cessation supplies and services,
- Cardiac rehabilitation,
- Pulmonary rehabilitation,
- Chemical dependence/mental health services,
- Diabetes education/nutritional counseling services, and
- Nutritional education services.

Children in the Enhanced Plan have access to Skilled Nursing Care (Private Duty Nursing). Also, individuals in the Enhanced Plan are not subject to a four prescription limit for pharmacy services which applies in the Basic Plan and for the standard Medicaid benefit. Enrollees who fail to comply with their member agreement, or in the case of children whose parent or caretaker fails to comply, lose access to the “enhanced” services. Table 6 summarizes the benefit design for each of the four states with DRA SPAs.

**Table 6. State DRA Alternative Benefit Design**

	<b>Idaho</b>	<b>Kansas</b>	<b>Kentucky</b>	<b>West Virginia</b>
<b>Benefit Design</b>	Three alternative benefit plans targeting different populations: Basic Plan: Healthy low-income children and adults Enhanced Plan: Individuals with disabilities and special health care needs Coordinated Plan: Individuals dually eligible for Medicare and Medicaid.	One alternative benefit plan, Working Healthy, which targets the working Medicaid buy-in population with developmental disabilities, physical disabilities, or traumatic brain injury.	Four alternative benefit plans targeting different populations: Family Choices: Medicaid categorically needy children and KCHIP children Comprehensive Choices: Elderly and disabled meeting institutional level of care Optimum Choices: Developmentally disabled meeting ICF/MR level of care ESI: Any enrollee except children with access to insurance through their employer.	Two Alternative Benefit Plans: Enrollment into Basic Plan with access to Enhanced Plan when Medicaid Member Agreement is signed; Compliance with agreement is required to maintain enhanced benefits.
<b>Mandatory Enrollment</b>	None	None	Family Choices has mandatory enrollment	All full benefit eligibles who are not exempt per DRA –i.e. healthy adults and children.
<b>Optional Enrollment</b>	Enrollment in all plans is optional, as all plans include participation by federally “exempt” populations.	Enrollment in the Working Healthy plan is optional.	Enrollment in Comprehensive and Optimum Choices is voluntary as is ESI.	None.
<b>Benefit Structure</b>	Benefits available in the Enhanced Plan but excluded from the Basic Plan: <ul style="list-style-type: none"> <li>• Partial care treatment</li> <li>• Intermediate care facility services</li> <li>• Nursing facility services</li> <li>• HCB waiver services</li> <li>• Hospice care</li> <li>• Intensive behavioral intervention and private duty nursing for children (unless school-based)</li> <li>• Case management services limitations in the Basic Plan</li> <li>• Inpatient mental health (10 days)</li> <li>• Outpatient mental health (26 services per year)</li> <li>• Adult preventive medical exams (1 per year)</li> <li>• Psychosocial rehab (school-based only)</li> <li>• Personal care services (school-based only)</li> <li>• Developmental therapy services (diagnostic and evaluation only).</li> </ul> Coordinated benefits are still under development.	Besides regular Medicaid benefits, Working Healthy includes the following benefits: <ul style="list-style-type: none"> <li>• Person-centered assessments</li> <li>• Personal assistance services</li> <li>• Independent living counseling</li> <li>• Assistive services (items or equipment that improve independence, employment, and/or health and safety).</li> </ul>	Global Choices (standard Medicaid): benefit service limits imposed for <ul style="list-style-type: none"> <li>• Home health services</li> <li>• OPS therapies</li> <li>• Audiometric</li> <li>• Chiropractic</li> <li>• Dental.</li> </ul> Benefit cost limits on: <ul style="list-style-type: none"> <li>• Prosthetics</li> <li>• Hearing aids for children</li> <li>• Eyeglasses for children.</li> </ul> Family Choices: <ul style="list-style-type: none"> <li>• More restrictive home health services limits</li> <li>• Less restrictive eyeglasses cost limits for children</li> <li>• No cost-sharing.</li> </ul> Comprehensive and Optimum Choices: <ul style="list-style-type: none"> <li>• Less restrictive OPS therapies limits</li> <li>• Less restrictive eyeglass cost limits for children</li> <li>• Lower cost-sharing.</li> </ul>	Benefits available in the Enhanced Plan but excluded from Basic Plan <sup>13</sup> for all affected members: <ul style="list-style-type: none"> <li>▪ Weight management</li> <li>▪ Chiropractic</li> <li>▪ Podiatry</li> <li>▪ Nutritional education.</li> </ul> Basic Plan excludes these enhanced benefits for adults: <ul style="list-style-type: none"> <li>▪ Inpatient psych</li> <li>▪ Tobacco cessation</li> <li>▪ Cardiac rehab</li> <li>▪ Pulmonary rehab</li> <li>▪ Chemical dependence/mental health</li> <li>▪ Diabetes education/nutritional counseling</li> <li>▪ Nutritional education services.</li> </ul> Basic Plan excludes these enhanced benefits for children: <ul style="list-style-type: none"> <li>▪ Skilled nursing care (private duty nursing).</li> </ul>
<b>Benchmark</b>	Secretary Approved for all three benefits.	Secretary Approved.	Secretary Approved except ESI which is benchmarked to state employee coverage.	Secretary Approved.
<b>Wraparound Benefits</b>	EPSDT treatment services for children under 19 are provided through the Enhanced Plan. Prevention and health assistance benefits provided to targeted individuals who use tobacco or are obese, and who have completed specified activities related to the conditions; these benefits include weight control and smoking cessation programs, nutrition counseling, and other health related benefits.	EPSDT for children under 19.	EPSDT for Medicaid children under 19  No other wraparound benefits, but state will offer Get Healthy Benefits for individuals with chronic conditions successful completion of a disease management program. Benefits include limited dental and vision services, smoking cessation and nutritional counseling.	EPSDT for children under 19.
<b>Implementation</b>	Statewide implementation. Enhanced and Basic plans already implemented. Coordinated Plan still under development.	Statewide	Statewide except for Get Healthy Benefits. State has several pilot projects targeting specific disease states.	Three county pilot with statewide phase-in as infrastructure allows.

### **Alternative Benefits and Missouri's Safety Net**

There is very little research on benefit design and its impact on health care costs and utilization, either within the commercial and private insurance markets or within public health programs.<sup>14</sup> In addition, the benefit redesign in the above states, with the exception of Kansas, were initiated within the context of comprehensive state Medicaid reforms that incorporate many other program elements that reflect specific state priorities, objectives, and political considerations. The impact of a particular benefit design will depend in large part on this broader context. For safety net providers the important questions to be addressed with benefit restructuring include the impact on access to services, health outcomes, and safety net funding streams.

#### **ACCESS AND BARRIERS TO SERVICES**

As is illustrated by the SPAs approved for each of the four states, the DRA benefit flexibility provisions can be applied in various ways from broad restructuring of benefits for all Medicaid recipients (i.e., Idaho) to a very narrow scope of benefits for a very limited population (i.e., Kansas' *Working Healthy Medicaid* buy-in program). Issues to consider include what types of restrictions are placed on what types of benefits, what options are available for recipients should their needs exceed benefit limits, and how difficult is it for beneficiaries to exercise their options. For instance, Idaho's automatic enrollment into an "optional" benefit plan and its proposed scale-back of the standard Medicaid entitlement both restricts options and increases the difficulty for recipients to exercise options.

#### **IMPACT ON HEALTH OUTCOMES**

Limiting access to specific benefits potentially can have a negative impact on health outcomes. However, when states customize benefits to meet the particular needs of recipients, health outcomes may be positively affected. Emphasis on preventive services for healthy populations, or on support services for the disabled, or care management services for the chronically ill can result in overall better health and quality of life, as well as reduced utilization of ER and acute care services. Safety net providers could benefit from reduced stress on their delivery systems that provide these services. Clinics and outpatient departments can be active partners in providing such preventive and health management services to the targeted population.

## IMPACT ON SAFETY NET FUNDING STREAMS

The benefit design could directly affect the funding stream for some safety net providers. For instance, the DRA requires assurances from states that utilize the alternative benefit flexibility that individuals will have access to FQHCs and RHC services. In addition, reimbursement for services to these important components of the safety net must comply with federal PPS methodology. However, concerns have been raised over whether states will adequately monitor and enforce these provisions. In addition, benefit structure could affect provider utilization patterns of Medicaid beneficiaries, especially when combined with changes in the delivery system. Idaho's proposal to provide coordinated benefits to its dual population through a managed care model has implications for hospitals that depend on supplemental payments such as DSH and UPL supplemental payments that are tied to Medicaid fee-for-service (FFS) inpatient and outpatient care (DSH and UPL issues are discussed later in the section on Finance Predictability).

These represent the broader concerns safety net providers should consider with any proposed benefit redesign. For Missouri, an additional issue that might be considered relates to eligibility cuts implemented in 2005. One question that can be raised is whether it would be possible for Missouri to provide an alternative benefit package for populations that lost coverage in 2005 if the state reinstated eligibility. As noted previously, states are restricted from using DRA benefit flexibility provisions to expand coverage to new Medicaid eligibility groups or for expansion populations already established under a waiver. This DRA limitation states: "The state may only exercise the option...for an individual eligible under an eligibility category that had been established under the state plan on *or before* the date of the enactment of this section."<sup>15</sup> (emphasis added)

Missouri may be able to make the case that this population was covered in the state plan prior to DRA enactment, and thus meets the criteria required under the law. Benefit flexibility may provide the state a means to cover a limited population with more limited benefits (i.e., a middle ground between elimination of coverage altogether and offering the full Medicaid benefit package). The obvious benefit for safety net providers is this could reduce the number of uninsured in Missouri, thereby reducing the pool of non-paying customers and increasing the pool of those reimbursed through Medicaid.

Idaho and Kentucky both have approved alternative benefit packages for federally “exempt” populations. Enrollment is voluntary. Missouri could make alternative benefits available to any of its various Medicaid populations on a voluntary basis.

Both Idaho and Kentucky have structured their programs to make the alternative benefits more attractive to encourage enrollment. In fact, states have considerable flexibility to amend their standard Medicaid benefits by either eliminating or limiting optional services under federal regulation, and enriching alternative plans. Missouri could take this approach to reinstate benefits cut in 2005. Furthermore it could target specific benefit plans for specific Medicaid eligibility groups or in specific geographic locations.

As is illustrated by the SPAs approved for each of the four states, the DRA benefit flexibility provisions can be applied in various ways from broad restructuring of benefits for all Medicaid recipients, such as was done in Idaho, to a very narrow scope of benefits for a very limited population, much like Kansas’ Working Healthy Medicaid buy-in.

Changing utilization patterns may also be an issue if the state should initiate a Health Opportunity Accounts demonstration. Medicaid payment rates for FQHCs and public hospitals are often times higher than other providers.

### ***Medicaid Buy-In Programs***

A number of states use Medicaid as the basis to leverage additional resources to expand health coverage to uninsured populations. Medicaid buy-in programs build on existing ESI through premium assistance or wrap-around services, or allow higher income individuals to “buy-in” to Medicaid coverage through cost-sharing structures. Many states have expanded coverage to parents of Medicaid or SCHIP children as well as working age childless adults through Section 1115 waivers and more recently through Health Insurance Flexibility and Accountability (HIFA) waivers which promote the use of commercial insurance through premium assistance.<sup>16</sup>

Expanding coverage to the disabled has also been a particular focus for Medicaid buy-in programs. As of August 2006, 36 states were operating Medicaid buy-in programs for the working disabled with over 75,000 enrollees.<sup>17</sup> Buy-in programs are an effective and efficient way to provide coverage for the disabled, who often face many challenges with health care. People with disabilities typically experience higher health care costs, barriers to accessing

commercial insurance coverage due to pre-existing conditions, and, when insured, often face inadequate coverage, since they frequently need benefits such as personal assistance with basic activities of daily living, adaptive equipment, or other types of supports not typically covered by commercial insurance.

For many individuals living with disabilities, appropriate health care can determine their ability to maintain employment. In addition, without the Medicaid buy-in option, many would face the frustrating dilemma of having to choose losing Medicaid health benefits due to increased income, or forgoing or limiting employment in order to retain Medicaid health benefits.

### ***Medicaid Ticket to Work and Buy-In Programs***

The Balanced Budget Act (BBA) of 1997 allowed states to expand Medicaid to disabled individuals who meet the SSI disability definition, who earn less than 250 percent of FPL, and who meet SSI unearned income and asset limit tests. Building on this legislation, the TWWIA, passed in 1999, gave states additional flexibility to set or eliminate income and asset standards so coverage could be expanded to working individuals between the ages of 16 and 64 with higher income levels, impose cost-sharing structures based on income within certain specified federal limits, and use Medicaid to wrap additional services around those provided through employer or private insurance. In addition, under federal TWWIA regulations, states cannot impose minimum earnings or hours worked requirements and have the option to extend coverage to individuals whose condition improves such that they no longer meet the SSI definition of disability but still have a severe impairment.

In an analysis of states' early implementation of Ticket to Work, the U.S. General Accounting Office (GAO) found that compared with the general working-age population, individuals with disabilities were more likely to be unemployed, have less education, and have incomes below 100 percent of FPL. However, the study also found that this population was less likely to be uninsured (i.e., an uninsured rate of 9 percent compared with 15 percent for the rest of the working-age population). Nevertheless, about half of those who were insured received coverage through public sources such as Medicaid and Medicare.<sup>18</sup> Further, in a more detailed analysis of four state buy-in programs, the GAO found more than half of participants had previous coverage under Medicaid and less than 10 percent reported having ESI when they enrolled in the buy-in program.<sup>19</sup>

In an analysis of earnings among 27 state Medicaid buy-in programs for 2004, researchers found that on average about 66 percent of all participants had reported earned income, but the average income was \$7,246 or only 78 percent of FPL.<sup>20</sup> While these measures varied considerably from state to state,<sup>21</sup> these data indicate that even with the supports offered through Medicaid and Ticket to Work, this population faces considerable economic challenges, and in the absence of Ticket to Work, many still qualify for Medicaid.

### ***Ticket to Work and the Missouri Safety Net***

According to the Center for Personal Assistance Services, in 2005 there were an estimated 937,000 Missourians over the age of 5 with a disability. This represents approximately 17.9 percent of the population. Of these, 526,000 are between the ages of 18 and 64.<sup>22</sup>

Missouri Medicaid experienced a significant growth in enrollment of the disabled population between 2001 (111,943 enrolled) and 2005 (159,535 enrolled). The average annual growth rate of 9.3 percent exceeded that of any other eligibility group. This was accompanied by an increase of nearly \$850 million in expenditures for this group over the same time period, accounting for nearly 50 percent of the total increase in Medicaid expenditures for all eligibility groups.<sup>23</sup> These increases reflect a state coverage expansion for the ABD population from 74 percent of FPL to 100 percent of FPL in 2004, and implementation of the Ticket to Work program in 2002. Because of the high cost of serving the disabled population, this increase in enrollment also likely contributed to the decision to make the eligibility cuts in 2005.

The 2005 legislation that scaled back Missouri's Medicaid program, eliminated the state's Ticket to Work initiative, known as Medical Assistance for Workers with Disabilities (MAWD). Table 7 describes the MAWD program when it was established in 2002. The program served nearly 18,000 at the beginning of 2005. When the program was eliminated in August 2005, approximately 8,000 individuals were found eligible for Medicaid through other eligibility pathways, but over 9,500 lost health coverage altogether.<sup>24</sup>

<b>Table 7. Missouri Ticket To Work Program in 2002</b>	
<b>Income limit</b>	250 percent of FPL gross income with no income disregards or unearned income limit
<b>Resource limit</b>	< \$1000
<b>Resource exclusions</b>	Retirement accounts, medical savings accounts, and independent living accounts
<b>Premium structure</b>	150% to 250% of FPL = 4 premium brackets from 4% to 7% of income.
<b>Work requirements</b>	Must be employed
<b>Protections with transition to other programs</b>	Independent living accounts are exempt from eligibility considerations until the age of 65

Source: Allen Jensen; George Washington University; *State Medicaid Buy-In Program Design Features: Comprehensive Person-Centered State Work Incentive Initiatives*; September 4, 2003.

Implications for safety net providers when either eliminating or expanding coverage for the disabled population can be profound. In 2006 the average annual per person expenditure for the disabled, excluding institutional and in-home care, was nearly \$12,000.<sup>25</sup> Assuming the 9,500 individuals that lost coverage in Missouri due to the elimination of MAWD had costs similar to the general disabled population, the impact equates to \$114 million per year in costs that are either shifted to safety net providers, to individuals out-of-pocket expenditures, and/or to foregone medical care. While it is possible that this population, which represents a presumably higher income group than those remaining eligible for Medicaid, could have lower per person health costs, it is also possible that in the absence of health care coverage, they delay or forego care that results in more acute conditions and higher costs when they do eventually seek care.

Safety net providers receive a double hit when individuals lose Medicaid coverage. These providers lose the income from Medicaid reimbursement for services they provide and see an increase in the number of non-paying customers. In a survey of Missouri residents that lost coverage when Medicaid eligibility and benefits were cut in 2005, 47 percent of respondents who lost MAWD said they would go to the local ER for health care and 26 percent said they would use a local free or community-based clinic. When asked how they would pay for needed care, 43 percent said they would cut back on the consumption of food and 47 percent said they would cut back on utilities.<sup>26</sup>

Conversely, reinstating the program, either in its previous form or in a modified version, could have an equally profound impact for safety net providers. Florida reported, for instance, evidence

that Medicaid expansions in the state decreased pressure on safety net hospitals by reducing uncompensated care.<sup>27</sup> The extent of the impact would depend directly on the structure of the program and its effectiveness at providing benefits needed by the population. Issues of concern to safety net providers would be:

- the breadth and scope of benefits,
- eligibility criteria and the number of individuals served, and
- cost-sharing structures that could discourage access.

### ***Family Opportunity Act***

After more than six years of Congressional effort to pass the Family Opportunity Act (FOA), it was finally adopted through the DRA. The DRA creates an optional Medicaid buy-in program for disabled children (as determined under the SSI standard for children under the age of 19) with family incomes up to 300 percent of FPL.<sup>28</sup> As a condition of coverage, states must require parents to buy-in to available group employer family coverage when such coverage is offered with the employer contributing at least 50 percent of the total cost of annual premiums. The state must then reduce the amount of the premium required for Medicaid coverage to take into consideration this contribution. The state may also provide premium assistance for ESI. States may impose income-related premiums with caps on aggregate premiums and total cost-sharing of 5 percent of family income for families earning less than 200 percent of FPL, or 7.5 percent of income for families over 200 percent of FPL. Eligibility for coverage is phased in by age over three years. During the first year (2007), enrollment is limited to children up to age six; in the second year (2008), enrollment is limited to children up to age 12; and in the third year (2009), all children up to age 18 can enroll.

This represents another opportunity for states to provide expanded coverage for the uninsured or underinsured through a Medicaid buy-in program. The primary difference between the FOA and other Medicaid programs for disabled children is that under the FOA, recipients are not required to meet an institutional level of care standard in addition to the SSI disability standard to receive services, and there is no budget neutrality requirement that care provided at home be no more costly than what could be provided in an institution.

## **Patient Responsibility and Empowerment - Consumer Involvement in Health Care Choices**

The DRA allows states to structure their Medicaid programs in ways that are intended to promote and encourage patients to become more actively involved in their health care and their health care choices. Under the DRA, states have wider latitude to enact strategies with the goal of increasing patient responsibility. Some of the most commonly used strategies include:

- increased cost-sharing requirements, either for co-payments or premiums;
- methods to make patients more informed consumers (e.g., consumer driven health care, client-centered planning, or efforts to promote transparency of health care costs and quality); and
- incentives for healthy behaviors, which usually involve member agreements and/or enhanced benefit accounts.

In states efforts to control Medicaid costs and keep budgets from spiraling out of control, they are turning to what have most recently been private sector strategies of giving consumers greater flexibility and choice in their benefit plans. This flexibility, while potentially producing cost savings to Medicaid, may have ripple effects across the rest of the safety net as it affects benefits and access to care. These types of strategies are very new and have yet to be evaluated to assess what impact (either positive or negative) they are having on patient outcomes, access to care, stress on the safety net, and savings to the Medicaid program. The following section describes strategies that are being employed and what select states are doing in regard to these strategies.

### ***Cost-Sharing***

Prior to passage of the DRA, Medicaid rules prohibited states from charging premiums to most beneficiaries and also prohibited imposing cost-sharing on specific groups, including children, pregnant women, and elderly and disabled beneficiaries who receive SSI cash assistance.

“Nominal” cost-sharing was allowed for some groups, but could not be imposed on any beneficiaries for ER visits, family planning services, and hospice care. Nominal is defined to include a deductible of up to \$2 per month per family, co-payments ranging from \$0.50 to \$3.00, and coinsurance not exceeding 5 percent of the state’s payment for the service. Federal law also required providers to render services regardless of whether the beneficiary paid the co-payment.

Subject to certain limitations, the DRA provides new authority for states to impose premiums and greater than nominal cost-sharing on some eligibility groups and for most Medicaid services.

Specifically, states may charge unlimited premiums and co-payments up to 20 percent of the cost

of services to beneficiaries with incomes above 150 percent of FPL. Beneficiaries between 100 percent and 150 percent of FPL can be charged co-payments up to 10 percent of the cost of services but may not be charged premiums. States may vary the premium and cost-sharing requirements by eligibility group and may also elect to allow providers to deny services if the co-payment requirement is not met.

SCHIP programs that are structured as Medicaid expansions must follow the Medicaid cost-sharing rules. In separate SCHIP programs, states may charge children premiums, enrollment fees, and other cost-sharing that, in the aggregate, do not exceed 5 percent of family income.

Under Section 1115 waivers, the federal government may permit states to modify current cost-sharing rules. Typically these modifications have applied to newly eligible expansion groups with incomes above the poverty level. For example, Missouri used its SCHIP funds to expand its Medicaid program to cover children with family income up to 300 percent of FPL using an 1115 waiver. Because the expansion occurred under a waiver, Missouri can charge premiums for certain children.

However, in the years leading up to the passage of the DRA, CMS allowed states to modify cost-sharing for currently eligible populations, particularly through HIFA waivers.<sup>29</sup> (The HIFA waiver option is specifically designed to help states extend coverage to uninsured individuals and affords states flexibility in benefit design and cost-sharing components of a program to expand coverage to the uninsured.) While CMS has issued guidance on submitting HIFA waiver proposals, it did not set a limit on total cost-sharing that may be imposed through a HIFA waiver, except for a limit of 5 percent of family income for children and “nominal” cost-sharing for mandatory populations.

#### IMPACT OF INCREASED COST-SHARING

The impact of cost-sharing on low-income populations is one of the most studied areas of health policy. Some theorize that premiums and point-of-service cost-sharing make people better health care consumers. Others believe that premiums discourage enrollment of low-income families and individuals and that point-of-service cost-sharing, even at relatively low levels, discourages people from seeking necessary care. For safety net providers, the impact of increased cost-sharing could be profound, especially if the latter theory holds true. Lower enrollment into Medicaid and SCHIP programs translates into larger numbers of uninsured, many of whom will use the ER as

their primary source of care. Similarly, to the extent that cost-sharing discourages individuals from seeking care early, safety net providers are more likely to treat individuals in ERs when they are experiencing acute episodes.

In the oft-cited RAND study, conducted in the 1970s and 1980s, researchers randomly assigned families to receive health care services for free or at varying levels of cost-sharing.<sup>30</sup> The study found that low-income adults made 41 percent fewer medical visits for “more effective” care (services that the researchers believed to be clinically effective in improving health outcomes) when they had to make co-payments than when they received free care. Co-payments also had a negative, though much less significant, impact on the utilization patterns of higher-income adults. Similarly, low-income children received 44 percent fewer clinically effective health care services when care was not free.

A more recent study analyzed the impact of cost-sharing on medical care use for acute care symptoms and on health status for chronically ill adults, a population that was excluded from the RAND study.<sup>31</sup> The study found that, among chronically ill populations, cost-sharing reduced the use of care for both minor and serious symptoms, though no differences in self-reported health status were observed.

Subsequent studies have examined the impacts of cost-sharing specifically on the Medicaid program, including several recent studies that looked specifically at new premiums and higher cost-sharing levels established under recent HIFA waivers. In some cases, these studies have examined not only the direct impact on beneficiaries, but also the impact on core safety net providers.

#### SELECTED STATE EXAMPLES - IMPACT OF PREMIUMS ON ENROLLMENT

Between April 2003 and July 2004, 16 states implemented new or increased existing premiums, or targeted premiums at families with lower incomes in their Medicaid or SCHIP programs.<sup>32</sup> The summaries below detail the findings in selected states for which data are available.

##### Missouri

In September 2005 Missouri began implementing new requirements that expanded premiums to families earning more than 150 percent of FPL. Previously, premiums only applied to families earning more than 225 percent of FPL. At the same time, the state also implemented a new

“affordability test” that denied SCHIP coverage to families who have access to “affordable” health insurance regardless of whether they are willing or able to pay the premiums.

State enrollment data indicate that the number of children enrolled in SCHIP declined by more than 24,000 from the time the changes were enacted (September 2005) and December 2006. This represents a decline of 26 percent in SCHIP enrollment for the period. This steep decline in enrollment is likely directly attributable to the new premiums, as well as the affordability requirements implemented in September 2005.<sup>33</sup>

### Oregon

In 2003, Oregon implemented several policy changes, including income-based premiums ranging from \$6 to \$20 per member per month and stricter premium payment policies which disenroll parents and childless adults who miss a single premium payment.

Following the premium changes, enrollment in the Oregon Health Plan (OHP) Standard Medicaid waiver program dropped by nearly 50 percent.<sup>34</sup> Most of the change was attributable to disenrollments, though some of the decline was due to a decline in new enrollments. The greatest enrollment losses were experienced by those in the lowest income groups.

### Rhode Island

In 2002, Rhode Island’s Medicaid waiver program (i.e., Rite Care) began charging premiums of between \$43 and \$58 per month to families above 150 percent of FPL. In the first three months under the new policy, 18 percent of affected families were disenrolled due to non-payment of premiums.<sup>35</sup> A survey of families who were disenrolled found that nearly half (48 percent) cited inability to afford the premium as the reason for losing coverage.

### Utah

In 2002, Utah became the first state to implement a waiver that reduced benefits and increased cost-sharing for existing Medicaid beneficiaries to finance a primary care benefit expansion (i.e., the Primary Care Network) for previously ineligible, low-income adults. To enroll, eligible adults had to pay a \$50 annual fee, which was later reduced to \$15 for adults receiving general assistance welfare payments and \$25 for all other eligible adults below 50 percent of FPL. Enrollees also pay \$5 to \$30 co-payments and up to 10 percent coinsurance for some services.

According to state figures, 27 percent of Primary Care Network enrollees were disenrolled from July through September 2003, when many enrollees were required to pay their annual fee to retain coverage.<sup>36</sup>

### Vermont

In 2004, Vermont increased its SCHIP sliding-scale premiums from \$20-\$50 every three months, to \$25-\$70 per month for families between 185 percent and 300 percent of FPL. The state also increased premiums from \$10-\$50 every six months to \$10-\$65 per month for adults between 50 percent and 185 percent of FPL enrolled in the state's Medicaid waiver program.<sup>37</sup> Finally, the state implemented new premiums of \$13-\$25 per month for adults between 150 percent and 225 percent of FPL enrolled in the state's pharmacy assistance waiver program for residents who lack prescription drug coverage. At the same time it increased premiums and added premiums for additional groups, Vermont eliminated virtually all co-payments and coinsurance in its medical assistance and pharmacy waiver programs.

Immediately following the implementation of the new and higher premiums, 11 percent of enrollees were disenrolled for nonpayment of premiums and the majority of these were still disenrolled a month later. A survey of individuals who were disenrolled found that 28 percent disenrolled because of cost and 30 percent disenrolled because they were confused or dissatisfied with the program.<sup>38</sup> Data indicate that many of those who disenrolled eventually re-enrolled in their respective programs.<sup>39</sup> However, overall enrollment across all affected programs remained below levels seen prior to the implementation of the premium changes.<sup>40</sup>

### Wisconsin

Since its implementation in 1999, Wisconsin's BadgerCare Medicaid waiver program for coverage of parents and children has charged premiums for families above 150 percent of FPL. An analysis of enrollment data indicate that premium-paying families experienced more "churning" (i.e., movement in and out of the program) than non-premium paying families, but the impact of the premiums appeared to be small.<sup>41</sup> Among individuals who disenrolled from BadgerCare, "premium-related reasons" (e.g., either an inability to afford the premium or to pay the premium on time) was the most frequently cited reason (26 percent) for disenrollment.

## SELECTED STATE EXAMPLES - IMPACT OF POINT-OF-SERVICE COST-SHARING

In recent years, several states have increased cost-sharing for Medicaid and SCHIP beneficiaries or imposed cost-sharing on additional populations. Nine states imposed new or higher Medicaid co-payments in fiscal year 2006 and three states are implementing new co-payments in FY 2007: one on ER services, one on drugs, and one state (Kentucky) is using the new DRA option to impose an array of new cost-sharing requirements.<sup>42</sup> Unlike premiums, which may impact an individual's or a family's decision to purchase health insurance coverage, the impact of co-payments or co-insurance is more likely to be seen in how, when, and whether an individual seeks out specific health care services.

### Kentucky

To date, Kentucky is the only state that has taken advantage of new DRA authority to impose higher than nominal cost-sharing on certain eligibility groups. Kentucky has imposed several new co-payments, including a \$50 inpatient hospital co-payment for non-institutionalized adults. Other services, including physician, lab, dental, and outpatient hospital services are also subject to new, mostly nominal, co-payment requirements. Co-payments are capped at 5 percent of family income.

Because the Kentucky policy changes have only been in effect since June 2006, data are not yet available on their impact. The state estimated that its entire Medicaid reform program (i.e., *KyHealth Choices*) would save the state \$1 billion over seven years, but assumptions as to how these savings would be achieved (e.g., through reduced utilization of specific services) were not disclosed.<sup>43</sup>

### Oregon

In addition to increasing premiums in its OHP Standard Medicaid waiver program, Oregon also implemented new cost-sharing requirements above the nominal amounts allowed under Medicaid law. Co-payments ranged from \$3 to \$250 and were later eliminated under court order.

A survey of adults subject to the new cost-sharing requirements who reported unmet healthcare needs found that 33 percent reported they could not obtain needed care due to cost, 24 percent said they did not have enough money to pay the co-payment, and 17 percent said they did not get care because they owed the provider money (responses were not mutually exclusive).<sup>44</sup>

## Utah

As noted above, enrollees in Utah's Primary Care Network Medicaid waiver program pay \$5 to \$30 co-payments and up to 10 percent coinsurance for some services. Compared with non-traditional Medicaid enrollees, who have broader coverage and lower cost-sharing, Primary Care Network enrollees were more likely to report missing or postponing getting needed medical care because of the cost or lack of coverage.<sup>45</sup> Primary Care Network enrollees' reports of missing or delaying care were much higher than national rates for Medicaid adults (36 percent versus 12 percent) and were comparable to national rates for uninsured adults with incomes below 150 percent of FPL (29 percent).

### IMPACT ON THE SAFETY NET

While only a handful of studies have specifically examined the impact of expanded cost-sharing on safety net providers, the pathways for potential impact are clear. To the extent that increased premiums discourage enrollment of eligibles or lead to increases in disenrollment, safety net providers are likely to see an increase in the volume of uninsured patients, particularly in hospital ERs. To the extent that increased point-of-service cost-sharing discourages beneficiaries from seeking early or preventive care, safety net providers are likely to see an increase in patients seeking care later than what would be considered optimal.

As noted above, Oregon experienced significant declines in enrollment after the implementation of higher premiums and stricter premium enforcement policies. During the first three months after the policy was implemented, visits to an ER of a major safety net hospital increased by 17 percent.<sup>46</sup> In addition, ER utilization increased among those who lost Medicaid coverage, especially among the lowest income groups and individuals with chronic conditions.<sup>47</sup>

A study examining the impact of the policy changes on health centers in Oregon found that clinics reported diverting substantial resources toward finding resources for patients who had lost their Medicaid coverage.<sup>48</sup> It was also reported that many FQHC patients could not afford the new co-pays, which contributed to a higher rate of no-shows for clinic appointments, including those patients who do not come back for a follow-up visit because of a fear that they would have to pay a second co-payment or not get a prescription filled because of the co-payment.<sup>49</sup>

## **Informed Choice**

### CONSUMER DRIVEN HEALTH CARE

Consumer driven health care “generally refers to a health benefit design where consumers have a high deductible insurance plan, a personal account funded in various ways to pay for care, a gap between the annual amount put into the account, and an internet-based support system.”<sup>50</sup> While these types of plans have been put into place in the private sector, it was not until passage of the 2003 Medicare Modernization Act (MMA) that state Medicaid programs were able to follow suit. Florida and West Virginia have led the way in states taking advantage of the MMA, which allowed Medicaid programs to establish Health Savings Account (HSA) models. Florida’s waiver, approved in October 2005, combines an insurance model with a direct services model that offers beneficiaries HSAs for both discrete services as well as to fund premiums and copayments. Florida’s program includes comprehensive choice counseling, customized benefit packages, enhanced benefits for participating in healthy behaviors, risk-adjusted premiums based on enrollees’ health status, and state reinsurance to encourage the expansion of managed care to rural and underserved areas.

West Virginia’s Healthy Rewards Account program provides beneficiaries with financial credits to use for purchasing services not covered in the Medicaid package. Credit amounts are either added or deducted depending on pursuit of healthy behaviors and appropriate use of services. The program requires enrollees to sign a contract agreeing that they will pursue certain healthy behaviors. Those who do not sign the contract (or who do not meet the goals outlined for them within one year) will have their credits, and therefore their benefits, reduced. This may include loss of coverage for diabetes treatment, cardiac rehab care, mental health and substance abuse treatment, and dental care. Beneficiaries who do not follow the contract also could face caps on the number of prescriptions that would be covered or other benefits.

These states have not evaluated the effects of their HSA models on the greater safety net, but concerns about the impact of such programs has been discussed by the policy community. An issue brief disseminated by The Robert Wood Johnson Foundation’s State Coverage Initiatives program described a number of scenarios wherein Medicaid HSAs could have a negative impact on the broader safety net:

- States that implement insurance models, whereby the enrollee receives funds to purchase coverage in the private market, may decrease access to benefits such as mental health, substance abuse care, and dental health, which are often carved-out of private coverage

products. Enrollees would then either not receive necessary care, or seek it in the safety net, potentially straining an already weak system.

- States may not be able to continue to provide the same level of funding to enrollees' HSAs, which could lead to an erosion of purchasing power. As that purchasing power decreases, so too does beneficiaries' ability to access services through the private sector, with the same potential effects as described above.
- Shifting Medicaid beneficiaries into the private sector means less funding for safety net hospitals and providers, and less overall resources for cross-subsidization of care for the uninsured.

In regard to the last bullet, both Florida and South Carolina (which has a waiver pending that would provide funding to purchase state-approved insurance coverage) included in their waiver proposals specific funds to replace UPL resources that hospitals will almost surely lose due to these reforms.

In addition to Florida, West Virginia, and South Carolina, other states that have received approval to implement their DRA proposals focusing on consumer-directed health plans include Kentucky, Idaho, and Kansas. These states, along with the others described, will need to be observed in order to assess the potential positive or negative impact that Medicaid consumer driven healthcare strategies will have on their respective states' safety nets.

#### CLIENT-CENTERED PLANNING

A number of states received waivers to implement client-centered or "person-centered" planning models, which have a strong relationship to consumer-directed health plan models. However, in most cases client-centered planning focuses on Medicaid enrollees with developmental disabilities, and ties in to programs which provide services through HCB settings. One example is Maryland, which began enrollment in its *New Directions* waiver on July 1, 2005. *New Directions*, which allows Medicaid clients with developmental disabilities to self-direct their services, has set out to enroll 300 individuals over the course of its three-year demonstration period. Each enrollee develops a person-centered plan with support from friends and family, who helped him/her establish a budget to identify funding necessary for approved services. These services include assistive technology and adaptive equipment, accessibility adaptations, respite care, support services, supported employment, transportation, behavioral support, resource coordination, adult day care, and transition services.

Other examples of client-centered planning also focus on individuals with developmental disabilities. Five states received funding under the *Independence Plus* initiative (four 1915(c) waivers and one 1115 waiver) that allow enrollees to design a package of services and supports and to take charge of supervising and paying their caregivers. An additional 12 states received grants under *Independence Plus' Real Choice Systems Change* funding opportunity, which provided resources for states to plan and design self-directed care programs.<sup>51</sup> These programs were designed to be budget neutral, and therefore did not present additional costs to their states' Medicaid programs. There have not been evaluations of whether these programs are having an impact on the greater safety net.

#### INCREASED TRANSPARENCY

States are becoming increasingly aware of the ways public reporting and transparency of cost and quality can improve the delivery of services and ultimately improve the cost-efficiency of the system as a whole. Transparency and public reporting of data on hospital and provider quality and efficiency measures are tied together. According to a report by The Commonwealth Fund, when public reporting and transparency are in place, “payers, federal and state governments...and professional societies are much better positioned to insist on high performance.”<sup>52</sup> The authors of that report recommend that a National Quality Coordination Board be created within DHHS to set priorities, oversee the development of quality and efficiency measures, ensure the collection of accurate data on these measures, and encourage the incorporation of these measures among Medicaid programs and other purchasers.

Currently, four states have received state plan approval for transparency-related strategies: Michigan, New York, Pennsylvania, and Wisconsin. Given that states are at the beginning of their quality and efficiency reporting efforts, there are no current tangible results. In some cases, states are still in the process of deciding which measures will go into their reports, at what level (i.e., individual provider, group practice or clinic, or hospital) they will report, etc. Because public reporting is not meant as a tool for changing access to care but rather improving quality and efficiency and eliminating inappropriate uses of care, it is not a strategy that tends to be seen as having a significant potential for affecting the safety net. States are hoping that providers and consumers will use the information to improve their practice patterns and make informed decisions.

There are several public reporting and transparency-related initiatives looking at the private delivery system, which may provide a template for state Medicaid programs. For example, Massachusetts Health Quality Partners (MHQP) has been collecting information from the state's five largest private health plans on quality measures since 1995. MHQP organizes the information according to medical groups, and posts the data on its website so that consumers can find information on the highest performing providers. And in 2002, the Wisconsin Collaborative for Healthcare Quality (Collaborative) formed to work toward increasing transparency among hospitals, health plans, and multi-specialty physician groups. The mission of the Collaborative is to use publicly reported data to “drive internal process improvement and have a positive influence within the health care community.”<sup>53</sup>

At this time, private sector efforts are leading the way in bringing transparency and public reporting to the forefront. The transparency movement is new and gaining momentum. While it will be important for states to watch how private sector efforts are faring, the potential for transparency and public reporting to have a significant impact on the safety net at this point is low. Evidence from the few efforts that are now in place indicates that consumer engagement is low, and they are not acting upon the information in public reports. In addition to the challenge of getting consumers (as well as purchasers and plans) engaged, is the challenge of finding the resources necessary to develop public reporting tools. As evidenced by the efforts of the Puget Sound Health Alliance,<sup>54</sup> which is hoping to release public reports on all providers in five Washington State counties, simply choosing which measures will be studied can be a very costly and time-consuming effort. Some of the most significant costs for the body overseeing the transparency effort come from establishing consistent measures across health plans, physicians, and hospitals. The plans and providers themselves often have to shoulder some costs in order to develop systems for collecting data on those measures.

### ***Healthy Behavior Incentives***

In promoting personal responsibility for health care, states are exploring a number of approaches which ultimately seek to change the individual behavior of their program members. Various initiatives, structured as either “carrots” or “sticks” or some combination, emphasize the importance of recipient participation in health care choices and responsibility for the consequences of those choices. Two examples of these include:

- member agreements and
- enhanced benefit accounts.

## MEMBER AGREEMENTS

Member agreements are a mechanism to impose personal responsibility for health care directly upon the member who is a party to the agreement. It consists of a pledge by a Medicaid recipient to comply with a set of principles or behaviors and is frequently accompanied by a set of consumer rights. In the past, where agreements were used, they were largely a statement of expectations. West Virginia has taken this concept up a notch and has conditioned access to certain benefits to signing and complying with a member agreement.

The concerns for safety net providers where a state utilizes a member agreement largely are dependent upon the scope of the agreement and consequences imposed upon enrollees for failure to comply. The potential direct impact on safety net providers in a structure like West Virginia's is related to provider utilization patterns and Medicaid reimbursement (or the lack thereof) for services provided to Medicaid recipients. Safety net providers are particularly sensitive to these two issues due to their relatively significant dependency on Medicaid reimbursement.

### West Virginia's Member Agreement and Benefit Structure

Under the DRA benefit flexibility provisions,<sup>55</sup> West Virginia became one of the first states in the nation to receive CMS approval for an SPA that establishes alternative benefits for individuals in its Medicaid plan.<sup>56</sup> The alternative benefit package under West Virginia's SPA provides an "enhanced" benefit package for beneficiaries that sign and conform to a "Medicaid Member Agreement" and a scaled-back or "basic" benefit package for those who either fail to sign the agreement or who do not fulfill their obligations under the agreement. The SPA alternative benefit package applies to "healthy adults and healthy children on Medicaid." The medically needy and other individuals that "spend down" to eligibility are explicitly excluded from participation, as are other population groups required to be excluded by the DRA.<sup>57</sup>

While the Basic Plan includes all required state and federal Medicaid mandatory benefits, it establishes limits on some services such as pharmacy (limited to 4 prescriptions<sup>58</sup> per year), non-emergency medical transportation (10 trips per year for children and 5 for adults), and home health (25 visits per year). The Basic Plan does not include the following services, all of which are included in the Enhanced Plan:

For Children:

- Skilled nursing care (limited to 180 days in the Enhanced Plan)
- Orthotics/prosthetics
- Tobacco cessation
- Nutritional education
- Diabetes care
- Chemical dependency and mental health services

For Adults:

- Cardiac rehabilitation
- Chiropractic services
- Dental services
- Tobacco cessation
- Chemical dependency and mental health services (limited to 30 days inpatient and 20 visits per year outpatient in the Enhanced Plan)
- Diabetes care
- Nutritional education

Access to each of the benefit packages is explicitly tied to the Medicaid Member Agreement. An individual must sign the agreement to be enrolled in the Enhanced Plan. Parents must sign on behalf of their children. The Medicaid Member Agreement includes the following 12 member responsibilities:

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.

- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital ER only for emergencies.

In order to retain the Enhanced Plan benefits, individuals must comply with the agreement.

During the first year, the state in partnership with the HMO or medical home provider is tracking compliance for the following four responsibilities:

- Screenings as directed by their health care provider.
- Adherence to health improvement programs as directed by their health care provider.
- Missed appointments.
- Medication compliance.

Members who do not fulfill these responsibilities will have their benefits reduced (to the Basic Plan), subject to “good cause” and with the right to appeal. After 12 months and at redetermination, members will have the opportunity to sign the Member Agreement and be re-enrolled in the Enhanced Plan.

West Virginia is the first state to test this approach which conditions a set of services on the behavior of an individual enrollee (or upon parents meeting obligations in the case of children). The state implemented this on a pilot basis in three counties July 1, 2006, and intends to extend it statewide over four years. While the initiative is too new to assess its impact, critics have raised a number of concerns.

- **EPSDT and Benefits for Children:**  
As is required by the DRA, West Virginia includes EPSDT<sup>59</sup> in the list of services for children under both the Basic and Enhanced benefit plans. At the same time, however, the Basic Plan for children excludes certain services that EPSDT covers and limits other services. As the Center on Budget and Policy Priorities (CBPP) noted, “There is a basic inconsistency here . . . .”<sup>60</sup> If, in fact, West Virginia denies coverage for diabetes care and mental health services to children who have been determined to need those services – as the scope of the Basic Plan suggests – West Virginia would be out of compliance with the federal EPSDT mandate.
- **Application and Enforcement:**  
The SPA indicates that providers will be used as the mechanism to monitor and report compliance with the Member Agreement. Besides the philosophical issues related to providers “policing” member compliance, uneven application and enforcement would seem inevitable under such a plan. For example, “adherence to health improvement

programs as directed by their health care provider” could be applied and interpreted quite differently from provider to provider. Further, the recent CBPP report cites a study that found providers made inferences about patients’ treatment compliance based on race and age. Another study in Florida (a state that required providers to report mothers known to have used drugs or alcohol during pregnancy to health authorities) found providers more likely to report African American women than white women and more likely to report poor women than non-poor women.<sup>61</sup>

- **Application of Member Agreement to Children and Teenagers:**  
The SPA provides that “Medicaid members” must voluntarily sign the Member Agreement and children are not explicitly excluded. Obviously young children, especially, could not be held responsible for the requirements in the agreement, so parents would sign for their children and be responsible for compliance. However, it is unclear whether teenage parents would be required to voluntarily sign the agreement and whether there would be a minimum age criteria applied for this purpose. If teenage moms are held accountable for “adherence to health improvement programs as directed by their health care provider,” would teenagers with no children also be held accountable? Further, if only the parents are required to sign the Member Agreement, is the state actually willing to reduce the child’s benefits if the parent fails to adhere to a health improvement program as directed by his or her physician? Apart from the EPSDT issues discussed above, critics find such a result to violate notions of fairness.
- **High Expectations and Unintended Outcomes:**  
The intent of West Virginia’s plan is to encourage individuals to get preventive care, comply with the care prescribed by their doctors, and to use the delivery system appropriately. Some argue that under West Virginia’s plan Medicaid recipients are held to higher standards and unrealistic expectations that do not exist in other health care delivery systems. For instance, a perspective analysis of the West Virginia plan contained in the *New England Journal of Medicine* cites research that found the rate of medication compliance in clinical trials to range from 43 to 78 percent.<sup>62</sup> There are many reasons for non-adherence to a health care provider’s directives or for missing appointments, for the general population as well as those covered by Medicaid. It is well documented that Medicaid recipients tend to face greater obstacles (e.g., transportation, child care, and cultural and language barriers) that complicate their utilization of services. The CBPP report<sup>63</sup> cites a 2004 study of approximately 100 West Virginia families with children enrolled in either Medicaid or SCHIP. Only 42 percent of those interviewed had access to their doctor after hours or on weekends, and a third were directed to go to the ER for services when their doctor was unavailable. Furthermore, if individuals lose access to needed services, such as diabetes care or mental health services, they could end up with more serious health conditions requiring more costly health care services, which would not be a beneficial outcome for the state or recipients.

### Implications for Safety Net Providers

West Virginia’s approach to reform is untested and has no similar counterpart in the commercial or private health care industry. The effectiveness of the state’s initiative to improve health and/or achieve savings can only be determined with time. The impact on safety net providers under such a system could be mixed. To the extent that members comply with an agreement, hospitals may

experience decreased inappropriate use of emergency facilities and increased use of primary care services, which would overall be beneficial. Hospitals could experience additional stress as outpatient services increase if there is a commensurate decrease in inpatient care. Outpatient services are typically subject to lower margins under Medicaid reimbursement policies.

On the other hand, to the extent that beneficiaries were unwilling or unable to comply with the agreement, the loss of critical benefits such as mental health services, cardiac rehabilitation, and diabetes care could increase ER utilization, or result in increased acuity of conditions for inpatient admissions. This is particularly true where a lack of follow up care or insufficient management of a chronic condition could have serious health consequences. The loss of these benefits could also increase reliance on safety net providers as a source of care for services that would no longer be reimbursed by Medicaid. The burden of “free” care would fall squarely on hospitals, FQHCs and other community providers as Medicaid recipients would find themselves in essence, “underinsured.”

#### ENHANCED BENEFIT ACCOUNTS

Rather than penalize recipients for “unhealthy” behavior, some states are exploring a “carrot” approach by rewarding “healthy” behavior. These rewards frequently come in the form of credits or funds deposited into an account for a recipient and provide recipients flexibility to use the accounts to purchase services or items not typically covered under the Medicaid program. These “enhanced benefit accounts” have various names but all have similar structures. A set of benefits is layered on top of the standard Medicaid benefits as a reward for “responsible” health care behavior. The distinction between what is considered a healthy behavior and what is considered a reward sometimes is blurred when comparing programs. For instance, one state may consider participation in a smoking cessation program a healthy behavior to be rewarded with a deposit into an account, while another state may consider this an additional benefit which may be purchased from the individual account.

The impact for safety net providers would again depend on the structure of the initiative. Since Medicaid beneficiaries retain their standard benefits (although if Idaho’s request for approval to reduce benefits in its Standard Medicaid benefit is approved, this may not necessarily be the case), the rewards are not likely to have a negative impact on providers. Increased use of primary care and disease management services could exert pressure on outpatient services, but safety net hospitals tend to support and encourage these types of utilization.

### Florida's Enhanced Benefits Account Program

Any person enrolled in one of Florida's recently implemented Medicaid Reform Health Plans (managed care) is eligible for an Enhanced Benefit Account. When a recipient engages in an approved "healthy" behavior, the account is credited with funds that can be used to purchase additional services. Credit is given for such activities as child wellness visits; dental, vision and other preventative care for children and adults; age appropriate screenings and exams; disease management participation for those with chronic conditions; smoking, addiction, and weight loss programs; compliance with prescribed medication; and keeping primary care appointments. Each activity has a per year limit for which credit can be received and the total aggregate credit value is limited to \$125 per enrollee per year.

Credits can be used to purchase an extensive list of non-Medicaid covered health care and personal care items such as over-the-counter medications, health supplies, dental supplies, lotions and sunscreen, and first-aid products.

Many of the activities eligible for credits are reported through an electronic tracking system by the reform health plans. Activities related to chronic disease management and tobacco or weight-loss must be reported by the member for credit.

The program was initiated September 1, 2006. Florida reports that as of December 2006, 8,502 members have received credits totaling approximately \$249,000. Only about 30 beneficiaries had used their accounts with approximately \$500 in total expenditures. However, the state estimates that annual funding for the program for 2006 – 2007 will be \$6.4 million.<sup>64</sup>

### Idaho's Preventive Health Assistance Program

Idaho includes a member agreement within its personal health account incentive program. The incentive initiative, called Preventive Health Assistance (PHA), has two components with different goals:

- The Behavior PHA targets Medicaid participants that smoke or who are obese;
- The Wellness PHA targets SCHIP participants that are required to pay a premium.

Under the Behavior PHA, individuals who meet the criteria for participation sign an agreement to participate in a weight control program that includes physical fitness, diet, and personal health

education; or in an approved tobacco cessation program, as applicable. These participants receive up to 200 points or dollars to use for weight loss program enrollment, tobacco cessation program enrollment and products, gym membership fees, and healthy lifestyle classes as long as all standards are met.

In the Wellness PHA, participants must keep child wellness exams and immunizations up to date. Vouchers worth 120 points or dollars per year are used for delinquent premiums, as long as the preventive services are current. If a member is not delinquent in paying premiums, the vouchers can be used for athletic safety equipment, or sports or gym memberships.

### Kentucky's Get Healthy Benefits

Kentucky combines the enhanced benefit account concept with chronic care management. Only individuals with at least one of several targeted chronic conditions are eligible to enroll. The state has identified several counties for pilot programs in the following health-related areas:

- diabetes,
- pediatric diabetes,
- pediatric asthma,
- pediatric obesity,
- adult obesity,
- cardiac,
- breast and cervical cancer,
- osteoporosis, and
- adult asthma/COPD.

With successful compliance in a disease management program, participants earn additional benefits that include up to \$50 for additional vision and/or dental services, or counseling services in smoking cessation or nutrition. Individuals have 6 months to utilize their benefits, and lose the benefits if they become ineligible for Medicaid.

### Impact on the Safety Net

An incentive program structured to provide benefits in addition to Medicaid standard benefits to reward desired behavior would not have a significant downside to safety net providers. Safety net providers can serve as active partners in disease management initiatives. In addition, if incentives are effective, providers may see a decrease in inappropriate use of emergency facility services, an

increase in outpatient wellness visits, and greater compliance with therapy regimens. Incentive initiatives that penalize behavior could also result in these positive results but the potential for incurring penalties brings greater risk to both recipients and providers. Costs associated with administrative functions could be a concern for safety net providers, depending on the state's systems and processes in place, as well as how and whether responsibilities for monitoring compliance are assigned to providers. Florida's initiative utilizes existing electronic processes to track an individual's preventative care utilization, combined with self-reporting of chronic care management participation. Thus the state has attempted to minimize the administrative impact on providers.

### Costs Associated with Monitoring Compliance and Enforcement

States will incur costs associated with monitoring patients' compliance with healthy behavior incentives and enforcing those incentives. While the structure of the incentive program will determine the extent of these costs, any program change that requires some level of additional state involvement or oversight has an associated cost. Programs with significant monitoring and compliance will clearly have higher costs than those with minimal oversight. Depending on the sophistication of the state's systems and ability to incorporate electronic processes, tracking and reporting could be labor intensive. Other program costs could include state staff time to develop, oversee, and publicize the program; computer programming time to create and maintain a compliance tracking system; and hard costs for educational and program materials to be distributed to both enrollees and providers. As with any program or policy change, the anticipated benefits of the program need to be weighed against the expected costs.

## **Quality Outcomes**

States have undertaken a variety of strategies focused on improving individual and system outcomes. State Medicaid programs are using a number of widely accepted strategies to not only improve quality outcomes, but to bring the issue of quality to the forefront by making consumers aware of indicators that relate to high performance health care. These strategies include:

- services integration, such as combining behavioral and physical health care;
- P4P, which seeks to incentivize health care providers to offer evidence-based and client-centered care;
- HIT, such as electronic medical records (EMRs); and

- Chronic disease management/chronic care management, which seeks to identify certain clients and enroll them in programs to better manage and coordinate their care.

Both the private and public sectors have become increasingly aware of the ways in which making improvements in quality of care can have a positive impact on cost effectiveness and health outcomes. While focusing on quality is viewed generally as positive, states need to keep in mind that there is still debate over the appropriateness of certain quality measures. This is a particular issue in regard to the elderly and low-income populations, who “may have criteria for quality care that differ from those of the employed nonelderly population, and may process and use available information in different ways.”<sup>65</sup>

### ***Service Integration***

Service integration, as defined by Washington State, involves “bringing different Medicaid-funded health services together in a coordinated, client-centered framework” to improve client services and satisfaction.<sup>66</sup> States are exploring service integration strategies in order to increase efficiency of care delivery for enrollees who receive both medical and behavioral health care services, which in many states are not coordinated.

Washington State is a leader in integrating delivery of behavioral health and medical care services to its Medicaid population. From 2003-2004, the Department of Social and Health Services (DSHS) reported 28 distinct service integration partnerships, coordinating care for children and adults. One of the most comprehensive is the Washington Medicaid Integration Partnership (WMIP), a demonstration project that began in January 2005 and operates in Snohomish County. The goal of WMIP was to integrate managed care services in mental health, drug and chemical dependency treatment, and medical care for its ABD population. On October 1, 2006, WMIP integrated LTC into its service delivery system. The program enrolled 2,590 individuals as of November 1, 2006. According to WMIP’s November 2006 baseline report, baseline average monthly FFS medical care expenditures for WMIP enrollees were \$461, compared to \$733 for those who disenrolled from the program.<sup>67</sup> Additionally, baseline average monthly fee-for-service aging and adult services expenditures were \$96 versus \$216 for disenrollees.

A recent evaluation conducted by DSHS, with support from the Center for Health Care Strategies ([www.chcs.org](http://www.chcs.org)), found that 40 percent of the clients included in this demonstration felt their care was better coordinated than before enrolling in WMIP.<sup>68</sup> In addition, 24 percent of enrollees said services provided by the health plan improved due to fewer delays while waiting for approval for

care, shorter waiting times for appointments for routine care, better customer service, and less paperwork.

It should be noted that 7 percent of clients thought their care coordination had declined. Additionally, clients' satisfaction was lower with WMIP than it had been through DSHS in the areas of accessing assistance by phone during office hours, getting help for an injury or condition that required immediate care, and prescription drug coverage.<sup>69</sup> DSHS estimates that the state elicits significant savings from integrating services. A recent study found that by integrating mental health treatment with medical care, up to 50 percent of the cost of such treatment was offset. Adding psychotropic medication into the mix offset costs by up to 64 percent.<sup>70</sup>

Other service integration programs include the Wisconsin Partnership Program (WPP), an integrated health and LTC program for the frail elderly and people with disabilities. The state has a number of community-based organizations providing integrated services, each serving up to 600 enrollees. Colorado, Vermont, and Tennessee also operate or plan to implement service integration programs.

#### **P4P**

CMS defines P4P as “the use of payment methods and other incentives to encourage quality improvement and patient-focused high-value care.”<sup>71</sup> According to the most recent Kaiser Family Foundation 50-state Medicaid Budget Survey,<sup>72</sup> 2007 will see more than two-thirds of state Medicaid programs adopting quality incentive programs that could be classified as P4P. Using a variety of measures to assess providers' performance in providing preventive care like immunizations and prenatal services, as well as specialty care for patients with chronic conditions, Medicaid programs often take advantage of the Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures developed by the National Committee on Quality Assurance.<sup>73</sup>

Twenty states had incentive programs in place as of 2005. New York State's *Quality Incentive*, in place since 2002, provides bonuses and performance-based auto-assignments to health plans contracting with Medicaid, using HEDIS (and HEDIS-like) measures to compare current year data with that of the two previous years to establish a quality benchmark. In 2005, the state's measures included breast cancer screening, postpartum visits, diabetes and high blood pressure control, use of appropriate medication for persons with asthma, and follow-up after

hospitalization for mental illness. The maximum bonus payment to health plans is 3 percent of the premium.

Over the course of the four-year program, the state has paid bonuses in the amount of \$71.5 million (\$51 million of that was paid in 2006). 2006 also saw four plans receiving the full 3 percent bonus, and one plan receiving over \$10 million. It should be noted that at the same time as some plans were performing highly, eight plans received no bonus payment. In terms of the program's effect on quality, the state has seen an increase in enrollment in plans that are identified as high quality, and a number of managed care plans have created performance programs that parallel the Quality Incentive program with their own providers.<sup>74</sup> Based on early results, the incentives seem to be having an effect on the quality of care. For example, the percent of women who were reported as receiving appropriate postpartum care rose from 49 percent of Medicaid enrollees before the quality incentives were in place to 68 percent afterward. In April 2006, New York issued a request for applications for P4P demonstration projects that provide incentives directly to PCPs for promoting patient safety and quality of care in Medicaid managed care.<sup>75</sup>

As illustrated by the above examples, P4P initiatives are designed to improve quality and efficiency of care delivered, rather than directly affect access to care. Given that, evaluations of these programs have examined the extent to which providers are changing practice patterns in order to meet quality and efficiency measure baselines. Because changes in provider efficiency and quality of care do not necessarily effect how safety net services are financed or delivered, there have not been any evaluations as to the effect of P4P on states safety net. Under certain scenarios there could potentially be some ripple effects from P4P on the safety net. For example, if a state decides to end its Medicaid managed care contract with a health plan because of poor performance, there could be access issues that may lead to increased safety net usage for some consumers. But thus far states are not taking such drastic steps.

P4P is also being used in the behavioral health delivery system. Iowa implemented P4P targeting behavioral health organizations (BHO) in 1995, using a combination of carrot, stick, and non-financial incentives. "Carrot" measures, for which BHOs may receive a maximum of \$1 million in bonus payments per year, include: consumer participation in joint treatment planning conferences; average time between hospitalizations; percentage of expenditures for integrated services, consumer-run programs, and home-based programs, as well as six others.<sup>76</sup> The measures were developed by the state with the assistance and approval of the Iowa Plan Advisory

Committee. An additional five measures are used as “sticks,” with plans receiving penalties for failure to meet benchmarks. These measures include timeliness of mailing new enrollee information, percentage of children discharged to homeless or emergency shelters, follow-up care within 72 hours of an ER visit, and percentage of claims paid or denied. Finally, reports on BHO performance are made available to state oversight bodies, giving contractors non-financial incentives to improve their performance.

### ***HIT***

In 2006, 29 state legislatures introduced or passed legislation related to integrating HIT into their health policy agendas.<sup>77</sup> Medicaid agencies are often leading the way in their states in terms of advancing HIT implementation. In fact, the DRA authorizes the federal government to grant \$150 million over two years to states for the “adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid.” The majority of proposals received under this grant solicitation were for HIT-related development, such as the creation of automation systems and electronic health records (EHRs). Examples include:<sup>78</sup>

- Wisconsin’s grant will be used to create a regional health information exchange framework, infrastructure, and system that will enable multiple hospitals, clinics, and health care institutions to rapidly and securely access medical history information about patients enrolled in the Medicaid and General Assistance Medical Programs (GAMP) in Milwaukee County. Access to patients’ medical histories across health care providers will help to reduce redundant tests and procedures, improve health care outcomes, and reduce health care costs. Wisconsin’s federal fiscal year (FFY) 2007 transformation grant allocation is \$1.85 million, with another \$1.2 million appropriated in the FFY 2008 budget.
- Utah is developing a Pharmacotherapy Risk Management System with an Electronic Surveillance Tool (Utah ePRM) that will help refine and implement a computerized surveillance and trigger tool to support medication therapy and risk management services. Additionally, the grant will enable the state to conduct innovative multi-pronged interventions that are guided by the ePRM trigger tool. The state’s FFY 2007 transformation grant allocation is \$1.4 million, with another \$1.4 million appropriated in the FFY 2008 budget.

As these projects begin, they are likely to have some impact on their states’ safety net systems. However, the extent of this impact has yet to be seen.

Aside from the transformation grants, New York State recently received \$3 billion via a waiver to fund its Federal-State Health Reform Partnership (F-SHRP). Half of the funds will be invested in HIT and facilities modernization. The state has already provided \$52.9 million in grants for state health information exchanges.

### **Chronic Care and Disease Management**

As of 2007, 38 states are reporting implementation of disease management and/or care management programs within Medicaid to address the rising cost of care for individuals with conditions such as COPD, CHF, asthma, and diabetes. Additional conditions being added to some states' programs include HIV/AIDS, hypertension, and hemophilia. A number of states, such as Washington and Indiana, have had programs in place for several years, yielding positive results. The Washington Medicaid Disease Management Initiative began in April 2002 and saved the state \$2 million in its first year. The Washington Medical Assistance Administration found that in 2002, the state saved \$250,000 in asthma care; \$375,000 in congenital heart failure care; \$900,000 in diabetes care; and \$680,000 in renal disease care.<sup>79</sup> The state is currently conducting a thorough evaluation of the program and results will be forthcoming.

Indiana is also considered a leader in the area of chronic disease management. Its Indiana Chronic Disease Management Program (ICDMP) targets patients diagnosed with diabetes, CHF, asthma, and chronic kidney disease. An ongoing evaluation is being conducted by the state that looks at patient behavior, hospitalization rates, drug utilization, member satisfaction, and cost and quality indicators. Researchers found the most significant savings elicited by the ICDMP were for the CHF population. Between September 2003 and May 2005, costs for this population decreased by \$720 per member per month. The state estimates that the program could save up to \$29 million in costs for chronic care overall.<sup>80</sup>

While Indiana and Washington are considered leaders in this area, other states with comprehensive Medicaid Disease Management programs include New Hampshire, which targets COPD, end stage renal disease, and coronary artery disease; North Carolina which targets diabetes, asthma, CHF, and Attention Deficit Hyperactivity Disorder; and Colorado, which targets schizophrenia, high-risk neonates, and breast and cervical cancer (through six separate pilots, each funded by pharmaceutical companies). In recent years, chronic disease management has been viewed as a way to save on the cost of caring for the chronically ill in Medicaid, a population that uses a disproportionate amount of care. While these programs have been successful, it is important to note the challenges involved in implementing successful, sustainable chronic disease management programs. Among these is the high turnover among enrollees (often due to eligibility issues) and dissatisfaction among providers due to low reimbursement rates for managing care. Both of these hamper the potential scope and impact of the programs.<sup>81</sup>

## **Private Solutions Versus Public Provision**

The DRA expanded the ability of states to use private financing arrangements, such as LTC Partnership Programs. The DRA permits states to authorize insurance products which combine long-term care benefits with asset protection. In other words, a partnership is formed between Medicaid and LTC insurers that provides protection to beneficiaries against impoverishment due to the costs of LTC. Purchasers are insured for long-term care up to a pre-set dollar amount through the private insurer. Once the private insurance is exhausted, beneficiaries can continue to receive LTC care under Medicaid without spending their assets. Additionally, these plans exempt protected assets from Medicaid estate recovery requirements. The professed goal of such programs is to encourage advanced planning for LTC needs and to promote increased private financing of those needs.

### ***LTC Partnership Programs***

The impact of the country's aging population is a major concern for health policy analysts and especially for public health providers as they search for ways to address the strain on budgets and health delivery systems. According to the Congressional Budget Office (CBO), in 2004 Medicaid paid for 35 percent of the cost of all LTC services, followed by personal expenditures (33 percent), Medicare (25 percent), and private insurance accounting for only 4 percent of spending.<sup>82</sup> CMS reported that Medicaid accounted for 41 percent of nursing facility and home health care spending for a total of \$158.4 billion in 2004. Personal out-of-pocket sources covered 23 percent, while Medicare covered 20.4 percent. Private insurance sources accounted for only 9 percent.<sup>83</sup>

In the absence of LTC insurance, it is believed that many individuals divest themselves of assets in order to qualify for Medicaid as a means to cover their LTC costs. While debate exists concerning the number of individuals that qualify for Medicaid who could afford to pay for their own care, most of those who do qualify for LTC are impoverished either before they need the care, or through purchasing such care. In an analysis of community elderly at high risk for nursing home services, researchers found that 62 percent had assets that would be exhausted within one month of admission and that in the broad elderly population two-thirds have insufficient resources for one year of LTC, which on average costs in excess of \$70,000.<sup>84</sup>

Analysts point to the characteristics of LTC that imply insurance is the appropriate mechanism for its provision:<sup>85</sup>

- individual need for LTC is unpredictable in terms of the likelihood of needing services, when they are needed, and for how long the services will be needed;
- the financial cost of LTC is catastrophic, requiring more resources than many people, particularly those with limited incomes, can save; and
- the risk of requiring services increases with age at a time when personal resources are being depleted.

The DRA includes expansion of what are known as LTC Partnership Programs. All states are now allowed to authorize insurance products which combine LTC benefits with asset protection from Medicaid eligibility determination when the coverage benefits are exhausted, and protected assets are exempt from Medicaid estate recovery requirements.<sup>86</sup> The intent is to encourage advance planning for LTC needs and promote increased private financing for those needs. Access to Medicaid means that benefits under the LTC policy can be time limited and thus made more affordable to purchase.

The impact of a Partnership program on any state's safety net will be indirect and gradual over the long term. LTC insurance coverage is purchased several years in advance of needing the benefits and projecting uptake, need, and utilization over the long term is extremely difficult. In addition, LTC insurance is not an option for the aged and disabled who are currently in need of, or at-risk for institutional care. Because of this, and the relatively small pool of individuals who have purchased Partnership policies to date (and an even smaller pool that have exhausted benefits and are eligible for Medicaid) speculation concerning the impact must be treated with caution.

## BACKGROUND

The Partnership program was created by the federal government in the 1980s. However, amidst concern about its impact on Medicaid expenditures and departure from Medicaid's mission to serve low-income and impoverished populations, a moratorium was established on new programs in 1993.<sup>87</sup> Four states which had implemented programs were allowed to continue them: California, Connecticut, Indiana, and New York. Although the moratorium was eventually lifted, the assets of policy holders were subject to estate recovery requirements for new Partnership programs. If a policy holder accessed Medicaid services, upon the policy holder's death states were required to recover an amount from the estate up to the value of Medicaid services provided. This proved to be sufficient disincentive for any additional states to implement a Partnership program.

Essentially two types of coverage are offered in the existing programs based on asset protection. California and Connecticut policies offer dollar for dollar asset protection based on the value of the policy. For every dollar of LTC benefit coverage purchased, an equal value of assets is disregarded in determining eligibility for Medicaid should a policy holder exhaust insurance benefits. The other type of coverage offered in New York allows policies with total asset protection when a specified coverage threshold is purchased. Indiana offered both types of protection.

**Table 8. LTC Partnership Programs  
Cumulative Experience in Early Implementing States<sup>88</sup>**

	<b>Type of Coverage</b>	<b>Program Implementation Date</b>	<b>Total Policies Purchased/ Number in Effect</b>	<b>Total Receiving Benefits</b>	<b>Total Exhausting Benefits</b>
<b>California</b>	Dollar for Dollar	August 1994	97,223/ 81,259	1,270	143
<b>Connecticut</b>	Dollar for Dollar	March 1992	42,730/ not available	588	36
<b>Indiana</b>	Hybrid	May 1993	39,063/ 32,115	391	18
<b>New York*</b>	Total Asset Protection	April 1993	69,690/ 53,344	1,649	N/A

\*New York currently offers dollar for dollar policies as well as total asset protection.

**PARTNERSHIP PROGRAMS AND THE DRA**

The DRA allows an exception to Medicaid estate recovery requirements for individuals who participate in a Partnership program. The exception is equal to the amount paid under the LTC insurance policy and is disregarded in determining Medicaid eligibility.<sup>89</sup> New Partnership policies must provide dollar for dollar type of protection and meet certain conditions in order to be a “Qualified Partnership.”<sup>90</sup> These include:

- A Partnership policy must meet specific requirements of the National Association of Insurance Commissioners (NAIC) such as guaranteed renewal and various consumer protection requirements including disclosure, prohibitions on limitations and exclusions, marketing, pre-existing conditions, and probationary periods.
- The policy must cover a person that was a resident of the Qualified Partnership state when coverage first became effective.

- The policy must meet the Internal Revenue Code LTC insurance definition.
- The policy must not have been issued earlier than the effective date of the SPA.
- The policy must include inflation protection as follows:
  - For purchasers under 61 years old, compound annual inflation protection;
  - For purchasers 61 to 76 years old, some level of inflation protection; and
  - For purchasers 76 years or older, inflation protection may be offered but is not required.
- The state's Medicaid agency must provide technical assistance to the state insurance department regarding Partnership policies. The insurance department must assure that those who sell Partnership policies have appropriate training.
- The state may not impose any requirement affecting benefits or the terms of a policy unless it imposes the same requirements on all LTC insurance policies.

In addition, the Secretary of DHHS is required to develop portability standards to address reciprocal treatment of policies among states with Partnership programs, and to establish reporting state reporting requirements.

#### Issues

Partnership policies in force in December of 2003 represented only 1.5 to 5.7 percent of the elderly populations in those states with programs, which is much less than the 16.6 percent national average LTC insurance policy purchasing in 2000.<sup>91</sup> The low penetration rate is only one of many criticisms directed at the programs. Other concerns include:

- They do not address immediate LTC needs for those individuals currently at-risk for nursing facility care;
- They are not affordable for many individuals with lower incomes, and they are not currently an option for those with serious chronic health conditions;
- Their appeal to higher income individuals could result in erosion of the Medicaid safety net for low-income families by shifting resources to those less in need;
- Access to HCBS through Medicaid is limited and varies from state to state. This could result in higher nursing facility utilization in those states and increased demand for HCBS that already have substantial waiting lists;
- Individuals who exhaust their insurance benefits are still required to meet a state's level-of-care needs to qualify for Medicaid. These criteria vary considerably from state to state so access to services would also vary considerably, complicating attempts to both standardize the industry and establish reciprocity between the states.

These issues have implications for the amount and type of services available to individuals who purchase protection, as well as attempts to impose greater standardization and portability of Partnership products.<sup>92</sup>

In FY 2006, Missouri Medicaid served approximately 80,000 elderly recipients with a total cost of \$1.2 billion. LTC services accounted for nearly 65 percent of expenditures for the elderly and approximately 15 percent of total Medicaid expenditures.<sup>93</sup>

Missouri is one of 21 states that have Partnership program authorizing legislation as of passage of the DRA. While Missouri has program authorization in place, it never implemented its program. As noted above, none of the states implemented their Partnership program (beyond the four states whose program was grandfathered and therefore not subject to the estate recovery provisions).

Debate continues over the impact Partnership programs may have on Medicaid expenditures. From a practical and simple perspective, the insurance represents a shift in the source of funding for care. To the extent that Partnership programs result in individuals purchasing LTC insurance (who otherwise would have relied on Medicaid for coverage), the cost of care is shifted from the state to the policy holder in the form of premium payments and then to the insurance company when benefits are accessed. The state would realize savings as LTC insurance coverage would delay or possibly avoid access to Medicaid altogether.

To the extent that individuals substitute Partnership insurance for LTC insurance they would have purchased anyway, the shift is from one type of coverage to another. However, Medicaid programs are at-risk of increased expenditures if they end up serving individuals that otherwise would have funded their own LTC by spending down assets.

The CBO estimated that the LTC Partnership expansion would result in additional spending of \$26 million from 2006 through 2010 and \$86 million from 2006 through 2015, but offers no data or information supporting these estimates. Analysis of the impact of existing programs is inconclusive but seems to indicate that the programs are either budget neutral or result in moderate savings.<sup>94</sup>

The Partnership programs offer indirect benefits that may offset the risk to Medicaid. They can serve to promote consumer insurance protections, and quality products at a more affordable cost.

They can help stabilize the LTC insurance market through improved policies and options. Increasing participation in LTC insurance can lead to a more dynamic insurance market outside of the Partnership plans.<sup>95</sup> Perhaps the most significant benefit is that to the extent Partnership programs encourage the purchase of LTC insurance, more consumers may avoid impoverishment resulting from the cost of LTC. Poverty is linked to many adverse health and welfare outcomes and while insurance may not eliminate these conditions, it could serve to mitigate them.

## **Finance Predictability**

### ***Revenue Preservation***

Most states have developed several mechanisms to generate the non-federal share of Medicaid expenditures and maximize federal matching funds. As states embark on Medicaid reform, they are also working to develop reform strategies that will not conflict with the goal of preserving both existing and potential revenue preservation strategies. States have used a variety of strategies to implement Medicaid reform while preserving federal safety net funding.

Consistent with the federal-state partnership under Medicaid, States have considerable flexibility in designing payment methodologies for Medicaid services. In general, payments for Medicaid must be consistent with “efficiency, economy and quality of care.”<sup>96</sup> In addition to this broad requirement, Medicaid payments are subject to several federal requirements that govern how states may raise the non-federal share of Medicaid expenditures, as well as certain limitations on how states may pay providers:

- *IGT*- Federal Medicaid law explicitly allows state and local governmental units (including public providers) to transfer funds to the state as the non-federal share of Medicaid payments.<sup>97</sup> IGTs are widely used to provide the non-federal share for state DSH programs and UPL programs.
- *Certified Public Expenditures (CPE)*- Public providers have always been and continue to be able to provide the true local tax expenditure as a legitimate source of the non-federal share of Medicaid payments. Under a CPE arrangement, the provider certifies incurred expenses up to cost and the federal share of the Medicaid payments are remitted to the provider. Providers must maintain adequate accounting records to document this method of providing the non-federal share of Medicaid expenditures.
- *UPL*- Federal Medicaid regulations place an aggregate limit on payments that may be made for certain types of Medicaid services, including inpatient and outpatient hospital services and nursing facility services. Current regulations<sup>98</sup> divide hospital and nursing facility providers into three groups (i.e., private, state-owned, and non-state government owned) and dictate that Medicaid may not pay providers in these groups, *in the aggregate*, more

than what Medicare would pay for similar services ([or, in the case of physician services, average commercial rates](#)). Many states use UPL programs to provide supplementary funding to key safety net providers, including hospitals, physicians, and clinics that provide a large volume of care to Medicaid and uninsured patients.

- *DSH Payments*- The Medicaid DSH program provides additional payments to hospitals that serve a high volume of Medicaid and uninsured patients.<sup>99</sup> In response to rapidly escalating DSH payments, Congress capped the DSH program in 1991, creating individual DSH allotments for each state. Missouri's DSH allotment is approximately \$730 million (federal and state). Federal Medicaid law establishes minimum criteria for hospitals that must receive DSH payments, but states are free to expand the eligibility criteria to include additional hospitals. DSH payments to any individual hospital cannot exceed the cost of caring for the uninsured plus the hospital's Medicaid shortfall (i.e., the difference between Medicaid costs and Medicaid payments).
- *Provider Taxes and Donations*- Many states have implemented provider taxes as a source of the non-federal share of Medicaid payments. Under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991,<sup>100</sup> provider taxes must be broad-based and uniform, and cannot include hold-harmless provisions. This legislation also restricted the use of donations for the nonfederal source of matching funds. Provider-related donations were eliminated as a source of matching funds, except for donations that meet very strict "bona fide" donation criteria.

Like most states, Missouri currently utilizes several of these mechanisms, including a provider tax program known as the Federal Reimbursement Allowance (FRA) program, to generate the non-federal share of Medicaid expenditures and maximize federal matching funds within the limitations set by federal law and regulation.

### ***Medicaid Reform and Revenue Preservation Strategies***

Medicaid payment methodologies evolve differently in every state in response to specific policy objectives (e.g., enhancing access for specific services), political considerations, and the desire to maximize federal Medicaid matching funds received by the state. Understanding not only the mechanics but also the rationale behind certain reimbursement decisions is critical when evaluating Medicaid reform proposals that may affect how funds flow to the state and to individual providers. In addition, reform efforts that redirect Medicaid funds from direct provider payments (e.g., DSH or UPL payments) toward providing expanded coverage for previously uninsured individuals are sometimes viewed skeptically by Medicaid providers, despite their laudable goals.

In addition, it is important to note that it is the current policy of CMS to scrutinize state reimbursement methodologies when reviewing even unrelated SPA proposals from states. CMS

has been particularly concerned about UPL programs and related IGTs. Thus, it is likely that Missouri's current Medicaid financing strategies and payment methodologies will be carefully reviewed by CMS and become an integral part of federal-state negotiations over Missouri's Medicaid reform efforts. It is also important to note that CMS recently issued new proposed rules that may have a dramatic impact on how states utilize certain revenue preservation strategies. Depending on their content when they are issued in final form, these rules could have a significant impact on the Missouri safety net irrespective of any additional Medicaid reform efforts.

As proposed, these rules set significant new limitations on:

- The amount of Medicaid funds that can be paid to governmentally-operated providers,
- The permissible sources of non-federal funds (i.e., IGTs would be limited to tax revenues; CPEs would only be allowable if the Medicaid payments are cost-based),
- The type of entities defined as "units of government" and permitted to provide the nonfederal share matching funds, and
- The retention of Medicaid payments - providers would be required to retain the state and federal share of all Medicaid payments received (e.g., transfers back to state government would be eliminated).

### ***Medicaid Managed Care and Revenue Preservation Strategies***

States considering implementing or expanding Medicaid managed care have quickly discovered a very concrete example of how Medicaid reform and revenue preservation strategies can interact or, in this case, conflict. As described above, federal Medicaid regulations limit the amount that can be paid to certain types of providers to the amount that Medicare would pay, a ceiling known as the UPL. Because states frequently pay their hospitals much less than Medicare rates, there is often significant room (the "UPL gap") to make supplemental payments to providers without exceeding the UPL. These payments are often financed through IGTs or provider tax programs.

In calculating UPL payments, states may only count services utilized by Medicaid beneficiaries *that are paid on a FFS basis*. Services provided through Medicaid managed care contracts are not counted. Therefore, each unit of service that is delivered through an MCO rather than on a FFS basis represents the loss of actual or potential UPL funds for the Medicaid program and Medicaid providers. The result is that states considering expanding Medicaid managed care must weigh the potential benefits of managed care (e.g., cost-savings, predictability, improved access, and quality) against the loss of UPL funds. In some cases, the potential loss of hospital UPL funds

related to this UPL/managed care limitation has become a barrier to state Medicaid managed care expansion.

In recent years, several states have grappled with this tradeoff and have successfully negotiated compromises with CMS (typically through Medicaid 1115 waiver agreements) that largely preserve UPL funds for the state and safety net providers while allowing the state to pursue its program goals through managed care. [In addition, at least one state has utilized the flexibility inherent in the principles of actuarial soundness to increase rates to providers via increased managed care capitation rates.](#)

### ***Selected State Examples***

#### **CALIFORNIA**

In August 2005, CMS approved a section 1115 demonstration waiver for California that included a major managed care expansion into additional regions of the state, as well as mandatory enrollment of seniors and the disabled into managed care. The special terms and conditions of the waiver approval included several provisions that restructured how the state financed its hospital payments, both to mitigate the tradeoff between managed care and UPL payment mechanisms and to address concerns raised by CMS that some of California's current financing mechanisms were inconsistent with federal policy.

The demonstration includes the creation of a Safety Net Care Pool that preserves federal funding historically used for supplemental payments to providers to help offset uncompensated care costs. An additional \$180 million annual allotment of federal funds is contingent on the State meeting specific milestones, including implementation of mandatory managed care for the ABD population and other goals. The demonstration also includes several other changes to how California finances and pays for Medicaid services, including replacing some IGT arrangements with CPEs and redirecting DSH payments from private safety net hospitals to public safety net hospitals.

#### **FLORIDA**

In July 2006, Florida began implementation of a broad Medicaid reform initiative that includes several fundamental changes in how the program operates.<sup>101</sup> In effect, the program will move from a "defined benefit" to a "defined contribution" program, whereby beneficiaries may use their risk-adjusted premium dollars to choose from a number of coverage options, including ESI or private individual insurance and Medicaid managed care options.

Prior to implementing its reform initiative, Florida projected that it would generate more than \$400 million in federal matching funds for hospital UPL payments, primarily through IGTs from county governments.<sup>102</sup> Protecting these funds became a key component of the reform initiative. Indeed, the state legislature made its action authorizing the state to move forward with the reform contingent on federal approval of a mechanism to preserve UPL funding for hospitals.<sup>103</sup> After lengthy negotiations, Florida agreed to terminate its UPL program in exchange for the creation of a new Low Income Pool (LIP) that would continue to provide direct support for safety net providers. The LIP includes an annual allotment of \$1 billion (federal and state share) for the five-year waiver period. This represents an increase of \$300 million per year over the prior UPL program.<sup>104</sup>

## MASSACHUSETTS

Similar to California and Florida, Massachusetts has also successfully negotiated a health care reform waiver that preserves their federal safety net funding and supports the state's comprehensive health care reform plan. As a condition for approval of Massachusetts' waiver renewal, CMS required a change in the method in which supplemental payments were made to two key Massachusetts safety net systems (i.e., Medicaid managed care plans run by the Boston Public Health Commission and the Cambridge Public Health Commission). Specifically, CMS wanted an end to the use of IGTs to generate the non-federal matching share of these payments. Supplemental payments to these two providers totaled roughly \$770 million, meaning that CMS's proposed waiver conditions put about \$385 million in federal matching funds at-risk (Massachusetts' federal Medicaid match rate is 50 percent).

To avoid the loss of this critical federal safety net support, Massachusetts proposed a new use for these funds. The funding would begin to be redirected to support the new insurance-based system proposed under the Massachusetts reform plan. State and CMS officials agreed to create a new, capped Safety Net Care Pool with the funding to be used to significantly reduce the state's uninsured population. The Safety Net Care Pool will subsume the state's preexisting Uncompensated Care Pool. The creation of the Safety Net Pool represents a significant change in direction for Massachusetts' safety net funding. While it does not mean that the current direct support for key safety net providers will end, it does signal the beginning of a transition of funding towards insurance coverage and, over time, a decline in direct payments to institutions and other safety net providers.

## MICHIGAN

The State of Michigan took a markedly different approach than the states above. With a Medicaid managed care penetration rate of 85 percent, the state had very little UPL room available. To maintain and enhance access to hospital services for Medicaid enrollees, the state levied a new assessment on hospitals statewide. Funds generated through the levy are matched and used to fund an increase in the capitation rates paid to Medicaid managed care plans in the state. The managed care plans, in turn, have agreed to use these funds to increase payments to their hospital providers to at least the equivalent of Medicaid fee-for-service rates. Under federal guidelines, Medicaid managed care capitation rates must be actuarial sound but are not subject to additional limitations. The principles of actuarial soundness allow sufficient room, in most states, to make reasonable and necessary rate adjustments.

### ***Managed Care***

#### MODELS OF MANAGED CARE

In the early 1990s, many states began to experiment with moving Medicaid beneficiaries out of the traditional FFS model of care into managed care arrangements ranging from PCCM to capitated integrated models encompassing acute/primary care, behavioral health care and LTC. For states, the models varied but the goals were consistent (i.e., better management of care resulting in improved quality of care, improved access to providers, and increased consumer satisfaction while at the same time better controlling costs.

In 2005, 48 out of 50 states had some form of Medicaid managed care enrollment resulting in almost 63 percent of Medicaid beneficiaries being served in some model of managed care.<sup>105</sup> States typically use one or more models of managed care, although as states have gained experience with managed care models, these models are being redesigned to meet the particular needs of a state or the population it is attempting to manage. A summary of the managed care models is provided below.

<b>Table 9. Six Models of Managed Care</b>
Full-risk HMO Model
Prepaid Inpatient Health Plan (PIHP)
Prepaid Ambulatory Health Plan (PAHP)
Primary Care Case Management (PCCM)
Enhanced Primary Care Case Management (EPCCM)
Program for the All-Inclusive Care for the Elderly (PACE)

It is important to understand the variation within and among states in using these models. Many states use different managed care models depending on the type of members (pregnant women vs. persons with disabilities and the elderly), geography (urban vs. rural), scope of covered services, and legislative direction. Arizona operates their entire Medicaid program under a capitated, comprehensive managed care model. With Medicaid Reform, Florida is attempting to move from multiple models to one statewide model, using a phased-in approach. Many states continue to operate a wide variety of models, which may or may not change as Medicaid reform efforts continue around the country.

**Table 10. Three State Comparison – Managed Care Models**

<b>Texas</b>	<b>Florida</b>	<b>Missouri</b>
<p>Full-risk HMO</p> <ul style="list-style-type: none"> <li>• Pregnant women and children in urban and contiguous counties</li> <li>• Persons with disabilities and the elderly in a subset of the urban and contiguous counties</li> </ul> <p>PCCM</p> <ul style="list-style-type: none"> <li>• Rural areas for all populations</li> <li>• Some urban areas for persons with disabilities and the elderly</li> </ul> <p>EPCCM<sup>106</sup></p> <ul style="list-style-type: none"> <li>• Dallas, Tarrant, and contiguous counties for persons with disabilities and the elderly</li> </ul> <p>PACE</p> <ul style="list-style-type: none"> <li>• El Paso and Amarillo</li> </ul> <p>PIHP</p> <ul style="list-style-type: none"> <li>• Mental health carve out in Dallas County and contiguous counties</li> <li>• Disease management for specific chronic diseases for all PCCM and FFS beneficiaries</li> </ul>	<p>Full-risk HMOs in non-reform areas</p> <ul style="list-style-type: none"> <li>• Women and non-special needs children – mandatory assignment</li> <li>• Dual eligibles excluded</li> <li>• Others voluntary</li> </ul> <p>Traditional PCCM: Non-reform areas</p> <p>Enhanced PCCM: Minority Physician Networks (MPNs) in non-reform areas</p> <p>Prepaid Behavioral Health Plans (carve-out) operating in non-reform areas</p> <p>Medicaid Reform:</p> <ul style="list-style-type: none"> <li>• Five counties</li> <li>• Currently includes acute/primary and behavioral health services</li> <li>• HMOs and Provider Service Networks only</li> <li>• Eventually will include some or all LTC services</li> <li>• Mandatory enrollment for most, excluding dual eligibles and special groups like persons with MR/DD who may voluntarily enroll.</li> <li>• “Specialty plans” – at present exist for children with special health needs.</li> <li>• Eventually to include most or all “special groups” including dual eligibles</li> </ul> <p>PACE</p> <ul style="list-style-type: none"> <li>• Miami</li> <li>• Expansion pending to two other areas</li> <li>• Acute/primary and LTC services Medicaid/Medicare capitation</li> </ul> <p>Nursing Home Diversion Waiver</p> <ul style="list-style-type: none"> <li>• Dual eligibles only with Part A and Part B Medicare</li> <li>• Acute/primary and LTC services (HCBS and nursing facilities)</li> <li>• Medicaid capitation only</li> </ul>	<p>Full-risk HMO</p> <ul style="list-style-type: none"> <li>• Parents, pregnant women, and children in St. Louis, Kansas City, Columbia, and Jefferson City area</li> </ul>

For all models, states determine the package of included services. Some states include all acute care services offered through the Medicaid program in that state. Other states integrate acute and LTC services. And, then, as in most aspects of Medicaid, there is a combination of both. When a state does not include a covered Medicaid benefit in the model, it is called a “carve out.” For example, some states do not include prescription drugs in the HMO model and instead pay prescription drug claims through the FFS system. Some states carve out mental health services and either pay for the service through FFS or create another model that manages mental health services separately from physical health.

### Full-Risk HMO Model

In the full-risk HMO model, states contract with licensed HMOs to provide a range of services for a specified population in exchange for a set per member per month payment (capitation). If medical costs exceed the capitation payment, the HMO is responsible for the costs. If medical costs are less than the capitation payment, the plan retains the excess funds. In exchange for the up and down side risk, the state gains budget certainty each year. This financial arrangement provides incentive for the health plan to manage the care with an emphasis on preventative and community based care rather than more expensive inpatient or institutional settings. However, states must be careful to have contractual provisions and oversight to ensure the health plan does not unfairly restrict access to needed services.

In addition to required contractual services, the health plan can provide additional services outside of the traditional Medicaid benefit package if it sees benefit to the member. For example, if a health plan determines home modifications will allow a member to leave the hospital sooner and receive appropriate and less expensive care at home, the health plan has the flexibility to pay for that service although it is not a state plan covered benefit (substitution). In addition to substitution, in some states like Texas, health plans offer value added services to members such as Weight Watcher memberships, boys/girls club memberships, and sports protective eyewear for children.

In the full-risk HMO model, Medicaid providers directly negotiate with the health plan for their rates and other contractual issues. The state does not participate in these negotiations. It is not uncommon for health plans to pay an equivalent rate to the historical FFS rates to some providers, although states do not typically require it. For some services, health plans may pay more or less than FFS rates, depending on the service and the provider.

Most states began implementation of the full-risk HMO model with pregnant women, children, and non-disabled adults. Now, with that experience gained, many states have begun or are exploring full-risk HMO managed care for persons with disabilities and the elderly. The elderly and people with disabilities represent a smaller percentage of Medicaid beneficiaries (27%) but a significantly larger percentage of Medicaid costs (66.5%).<sup>107</sup> In many states advocates have voiced concerns about the possibility of rationing of care for this population, which has much higher health care costs than pregnant women and children. States planning expansions of full-risk HMO model for elders and persons with disabilities often spend time in the planning and implementation phases addressing these concerns.

### PIHP and PAHP

PIHPs and PAHPs may be at-risk or may have some other type of state reimbursement and do not provide a comprehensive set of acute care services. A PIHP has the responsibility for the provision of any inpatient hospital or institutional services. BHOs responsible for psychiatric inpatient hospital services are the primary example of PIHPs. A PAHP has responsibility for some Medicaid services but does not have any responsibility for inpatient hospital or institutional services and is held to a limited subset of the federal managed care regulations applied to PIHPs and HMOs. Capitated disease management organizations and dental health plans are common PAHPs.

### PCCM

PCCM is a non-capitated model which focuses on creating a medical home for Medicaid beneficiaries through a PCP. Typically the PCP is paid a fee (\$1 to \$3 per member per month) by the state for providing care management. Provider contracts, fee schedules, and claims payment are the responsibility of the state. There is no financial risk for the PCCM administrator, rather the state pays all claims regardless of budgeted funds.

PCCM has shown to be more cost effective than traditional FFS but has not generated the same level of savings as the full-risk HMO model. Typically, providers prefer PCCM, citing it as less administratively burdensome than the HMO model. For rural areas, PCCM may be seen as a model to overcome regional barriers to managed care. A more limited provider base and fewer Medicaid beneficiaries can be difficult challenges for the HMO model.

**EPCCM**

In some states, additional elements of the HMO model have been incorporated into the PCCM model to increase management of care and decrease program costs. For example, some states have established or contracted for disease management programs for the PCCM population. These programs focus physician and member education on specific high cost/high prevalence disease states such as diabetes, asthma, and heart disease. Some states are also using disease management techniques for high cost cases rather than specific conditions. In EPCCM, there may be increased use of prior authorization, utilization management, and negotiated contract rates.

**PACE**

The PACE program provides pre-paid comprehensive services in a capitated arrangement for the frail elderly. This program integrates Medicaid and Medicare but has several program restrictions that have limited the size of the programs. To qualify for PACE, a person must be at least 55 years old and qualify for nursing facility level of care. In addition, all services must be provided at the service site so anyone joining PACE must live in the service area and be willing to receive all services at the PACE site. In 2005, the total Medicaid enrollment in PACE was 11,824 compared to over 28 million beneficiaries in other types of managed care programs.<sup>108</sup>

***Managed Care as a Piece of the Medicaid Reform Puzzle***

As states look for financial predictability in the Medicaid program, expansion of managed care models are being considered. Studies have shown the success of managed care in short- and long-term savings to the state compared to FFS.

**Table 11. Cost-Savings – Managed Care Models**

<b>State Program</b>	<b>Time Period</b>	<b>Savings Compared to FFS</b>
Arizona Full-risk HMO (non-disabled)	SFY 1991	19%
Wisconsin Full-risk HMO	SFY 2002	10.7%
Florida Full-risk HMO (non-disabled)	SFY 2007	8%
Florida PCCM	SFY 2000	15%
Texas Full-risk HMO (non-disabled)	SFY 2002	7.4%
Texas Full-risk HMO (people with disabilities and elderly)	Waiver Period 1 Waiver Period 2	17%
Texas PACE	SFY 2000	14%

Data Sources: Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies, The Lewin Group, July 2004. Texas A&M Public Policy Research Institute, Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality and Cost-Effectiveness of the STAR+PLUS program, June 2002. <http://www.cpa.state.tx.us/etexas2001/recommend/ch08/hhs21.html>

Safety net providers often face opportunities and challenges with managed care. The scale of these opportunities and challenges vary with each model. It is common in states for provider associations to oppose the full-risk HMO model, often citing increased administrative complexity. In the full-risk HMO model, when multiple HMOs participate in the program, providers must bill more than one claims payer, understand and follow multiple utilization management policies, and have multiple contracts. However, the full-risk HMO model has also been embraced by some safety net providers and led to participation as an HMO. For example, in Texas local hospital districts have formed HMOs to participate in full-risk managed care and in Florida, physician groups have formed HMOs. Non-capitated models, such as PCCM and EPCCM, have been more popular with providers but have not traditionally generated the same level of cost-savings for states.

## **HIT: Improving Performance Through Technology**

States over the last several years have been applying new technological solutions to the many challenges of administering their Medicaid programs. Some of those technologies have matured to the point where they can be identified as best practices. Others still are in their infancy. As states develop Medicaid reform agendas, they are drawing both from the proven technologies and those that show promise but for which there is little track record (at least in Medicaid).

### ***Moving Toward Real-Time Eligibility: The California Health e-Application Experience***

A number of states are experimenting with on-line application processes (many as a function of their separate SCHIP programs) and some are driving toward the goal of enabling families to apply for health coverage on-line and receive an immediate confirmation of eligibility and enrollment. To date, California's Health e-Application is one of the leaders.

The Health e-Application was developed through a partnership involving the California Health and Human Services Agency (CHHSA), the California HealthCare Foundation (CHCF), the Medi-Cal Policy Institute, and San Diego County. The solution design, processing and interface construction, and the engineering of the health plan and provider databases were all carried out by contracted vendors.

#### **KEY FEATURES**

The Health e-Application provides access to Medi-Cal (Medicaid) and Healthy Families (SCHIP). It is available statewide through Enrollment Entities, with development still underway

for a county-level single point of entry which would enable the county-based administration of the programs to receive the Health e-Applications electronically.

The technology is web-based which means it can be accessed from any web-enabled personal computer. The Americans with Disabilities Act compliant application is available in both English and Spanish and can be completed and submitted on-line. The process generally takes between 20 and 30 minutes, with preliminary screening completed in seconds. The application itself is the same for Medi-Cal and Healthy Families which means an applicant submitting the Health e-Application is applying generically for health coverage and not for one program or the other. In other words, if it turns out that an individual qualifies for either of the programs, the information they submitted on the application is accepted and the individual does not have to submit a second application.

The Health e-Application technology provides for instantaneous error checking. This eliminates a significant cause of delays in processing eligibility determinations which occur in less automated processes. In mail-based eligibility systems, applications routinely get pended until a letter can be generated requesting the correct information. That letter then must be mailed, the individual must assemble and mail the correct information, and it must be received and entered into the system by the agency or entity determining eligibility. (Note: Where the information can be conveyed over the phone, e.g., no corroborating documentation is required, this last delay can be eliminated in mail-based systems.)

Applicants also have the opportunity to select, at the time of online application, their health, dental and vision plans. They may also identify their PCP if they are enrolling in an HMO, as is the case for applicants who qualify for Healthy Families. In less automated processes, the applicant may be mailed a packet of information on their plan and provider choices once eligibility has been confirmed. The applicant then has to return their selections either by mail or by phone before enrollment can be completed and care can be accessed.

In the case of Healthy Families, applicants are able to pay their initial monthly premiums electronically at the time of application.

The actual processing of the information submitted by an applicant is done by a centralized third party administrator function which also makes the final eligibility determination in the case of

Healthy Families. The computing of income and deductions is automated as is the acceptance of electronic signatures.

The Health e-Application's web functionality also allows for online training of Certified Application Assistants (CAAs) who are used across the state to help applicants complete the process.

## **SOURCES OF EFFICIENCIES**

As noted above, the single electronic Health e-Application saves significant mail time compared to the traditional multiple paper submittals.

Due to the instantaneous error-checking function applicant errors are reduced which decreases interactions with families to secure missing information. In turn, this reduces mail time and the volume of telephone traffic at the contact center that handles all telephone communication with applicants.

Simultaneous application and selection of health plans and providers eliminates mail time associated with the traditionally sequential application and enrollment.

Electronic payment of premiums reduces manual processing of checks which is a potential source of human error.

Reduced reliance on paper reduces the potential for human error on the part of both the applicant and the program personnel responsible for receiving and entering the application information.

By reducing the time between application and enrollment, the Health e-Application gives the enrollee earlier access to care which in turn improves the chances that preventive and primary care will reduce the need for costlier medical procedures.

## **FORMAL EVALUATIONS**

The Health e-Application was piloted in January 2001 in low income/underserved areas of San Diego County. The results of the pilot were the subject of a business case analysis that focused on the benefits from the perspectives of key stakeholders and program administrators. Benefits were assessed in the areas of user satisfaction, efficiencies, accuracy and completeness of applications, and implementation issues for a statewide rollout.

In terms of user satisfaction, the analysis found that applicants had a heightened sense of confidence in the process and its outcome because of the real-time preliminary determination of eligibility. CAAs felt the Health e-Application made them more credible with the applicants and improved their efficiency, giving the CAAs a feeling of improved effectiveness. Eligibility workers and program administrators saw improvements in the completeness of applications and reductions in the amount of time necessary to process eligibility.

Efficiencies identified by the analysis included a reduction in application completion time across the two programs of 45-60 minutes. In the case of Healthy Families, the time from application submission to eligibility determination was cut by 3.5 days to 13.5 days. At the time of the review, further efficiencies were being projected as a result of modifications to allow electronic premium payment and the smoother handling and transmission of documentation with a further reduction of 3.5 days to 5 days.

Health e-Application cut the processing time for Medi-Cal applications from 44 to 35 days. Additional technical modifications were expected to drop another three days from the process.

Accuracy rates associated with Health e-Application were less than half those of the traditional paper process (2 percent invalid or incomplete data versus 5 percent). All Health e-Applications could be traced through every step of the eligibility process while slightly fewer than 2 percent of paper applications could not be tracked. With Health e-Application, 97 percent of the system's preliminary determinations of approved eligibility were subsequently confirmed by the third party administrator. What this meant operationally among other things was that the technology provided a reliable means of directing an application to the right program to complete processing once the preliminary determination had been completed.

The pilot identified a need for enhanced CAA training as a precursor to statewide rollout. Analysis of the pilot results also brought to light differences between state and county documentation requirements which needed to be reconciled to further improve the efficiency of the process. The review also found that the electronic images of documentation provided by applicants was more accessible and the submission and tracking of premium payments easier as a result of Health e-Application.

### **Connecting People and Services: Arizona's 2-1-1 System**

Following the Federal Communications Commission's July 2000 assignment of 2-1-1 "to be used to provide access to community information and referral services," the Phoenix-area United Way in 2001 launched a sub-state 2-1-1 effort. Nonprofit and public health and human services providers were brought together with Phoenix providers of information and referral services (I&R) and local government leaders to design a 2-1-1 capable of enhancing access to social services in the Phoenix metropolitan area.

In 2003, Governor Napolitano laid out a vision for a statewide 2-1-1 system. The state's HHS agencies began working with the United Way and local stakeholders to identify the requirements for the system through a series of regional town hall meetings and a system requirements summit. In the end, the operational and administrative requirements drove the design, emphasizing day-to-day capabilities and support for homeland security functions.

In the course of the requirements definition, the planning effort identified seven features believed to be key to the success of a statewide 2-1-1 system. Planning had to define the desired scope of the system. Priority was to be given to linking people in need of services to existing programs. The technology would rely on call centers and a 2-1-1 website. The system had to be designed in close coordination with the state's homeland security needs. Regional sensitivities and cultural issues within Arizona had to be reflected in the system. Finally, 2-1-1 had to be built on the foundation of an assessment of the state's infrastructure.

Launched in 2005, Arizona's 2-1-1 system required an initial development investment of \$500,000 and has an estimated five-year operating cost of another half million dollars. A total of 18,000 service entities were to be part of the system.

#### **KEY FEATURES**

The Arizona system is based on an executive order issued by the Governor and is overseen by a Governor's Council on 2-1-1. The Council is advised by a 2-1-1 Community Advisory Committee. Implementation has been under the leadership of a Project Management Team with the state's Medicaid agency charged with operating the system.

The state has undertaken the implementation in phases with the first phase being the development of a web-enabled database. The second phase has been the development of the infrastructure and

conducting of community outreach. Call center implementation is to be followed by the development and implementation of enhancements.

## **SOURCES OF EFFICIENCIES**

The 2-1-1 system is expected to improve the provision of services by expanding the availability of community resources beyond the state's at-risk populations. A statewide system is expected to reduce confusion and the margin of error for misdials as individuals use the single three-digit number of connect to the services they need. The consistency of a statewide system also is better suited to the needs of an increasingly mobile population. Finally, 2-1-1 also will serve as a resource for individuals seeking to volunteer their time and energy in service to their neighbors.

Arizona anticipates that 2-1-1 will help reduce the costs of public social services by facilitating early intervention and improving access to preventive services. That in turn should produce a healthier workforce whose productivity is improved as absenteeism is reduced. Through a centralized information and referral function, 2-1-1 is expected to reduce inappropriate calls to state and/or local entities providing health and human services, including calls to 9-1-1 by individuals seeking the status of an emergency, as well as duplication of I&R functions across the state.

The 2-1-1 system is expected to facilitate case management and access to appropriate services while reducing expenditure of resources by each service entity on raising its public profile and on staffing referral lines.

From a systemic standpoint, 2-1-1 will yield more data on which to base the assessment of service delivery systems and the assignment of resources to fill gaps. Arizona also anticipates that 2-1-1 will serve as a catalyst for using technology to streamline access to and delivery of services.

### ***Taking on the Utilization Driver of Prescription Costs: Florida's e-Prescribing Initiative***

In 2003, Florida's Governor and legislature initiated the development of a model for affecting health outcomes and addressing Medicaid prescription over-prescribing. This initiative puts handheld personal digital assistants (PDAs) in the hands of the state's health care providers.

## FEATURES

The e-prescribing effort was implemented in phases. In Phase I, 1,000 high volume Medicaid providers were given handheld access to the state's preferred drug list. They also could tap into 60 days of data in an individual patient's Rx history. Finally, the PDA put them online with utilization reports that included instances of interactions. Phase II was an expansion to 3,000 providers that allowed access to 100-day patient-specific Rx histories and included the e-prescribing function.

The e-prescribing function is supported by a web-based, real time capability. The provider can initiate a prescription from any web-enabled desktop computer or from a PDA. The prescription can be submitted electronically to participating pharmacies for dispensing of the compound and adjudication of the claim. The clinical information database with which the e-prescribing function is integrated uses screening tools to help prevent medication errors. Clinical pharmacology and clinical report tools provide the point-of-service capability to screen for potential adverse effects before the prescription is issued to the pharmacy.

The system can also generate a full history of any given prescription, including what was ordered by which provider for which patient at what time, where the prescription was sent, and when it was filled. Failure of the patient to pick up the medication can result in a system-generated notification to the prescribing provider.

Access to e-prescribing is at no cost to the provider. Electronic prescription and refill authorizations are accepted at 90 percent of participating Florida Medicaid pharmacies. e-Prescribing eliminates errors that arise from reading prescribing provider handwriting and it offers the provider a reliable source of documentation. e-Prescribing also has the potential to be integrated into a broader EMR system, bringing individual patient prescription data together with the rest of the patient's treatment history.

# STAKEHOLDER PERSPECTIVES ON MEDICAID REFORM

## Introduction and Approach

As a part of the review of the potential impact of Medicaid reform on safety net providers, interviews were conducted with Missouri safety net providers or their representatives in an attempt to document their perspectives on common Medicaid reform concepts (e.g., managed care expansion, tailored benefit packages, enhanced consumer involvement, and healthy behavior incentives). (See Appendix C for a listing of interviewees.) Ultimately, the impact of these concepts clearly depends upon how they are implemented. The goal of this section was to document broad perspectives, as opposed to specific critiques, on how these concepts might impact the safety net.

In determining which providers should be considered part of the safety net, the definition of safety net provider developed by the IOM was used. This definition states that the safety net includes “those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.” Most communities have a core of safety net providers which share two distinguishing characteristics:

- a legal mandate or explicitly adopted mission that they maintain an open door, offering access to services for patients regardless of their ability to pay, and
- a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.<sup>109</sup>

This series of interviews was limited in scope and size and clearly does not offer a large enough sample to be considered a definitive survey of safety net providers. Rather, the information gleaned from these interviews provides some general observations about the Missouri safety net’s viability and how Medicaid reform concepts can potentially affect that viability. Interviews were conducted from mid-January to mid-February of 2007, prior to the development of a concrete Medicaid reform proposal for Missouri. Thus, the feedback received was related to the general concepts likely to be components of Medicaid reform rather than a specific proposal offered by the Missouri legislature.

## **Findings**

### ***Current Issues Confronting the Safety Net***

The current state of the safety net will affect the impact of Medicaid reform on Missouri's safety net providers. The degree to which the safety net is already struggling with issues such as capacity and viability provide some indication of where the safety net is most strained and what specific factors contribute to those stressors.

There was overwhelming consensus among the individuals interviewed that the Missouri safety net is "fragmented, fragile, and under increasing pressure." Increases in the number of Missourians who are underinsured or uninsured (due both to cuts in Medicaid eligibility and services, as well as declines in ESI) have prompted many safety net providers to make adjustments in the way they do business. Safety net providers have adopted various strategies to stretch their resources including: converting to next day scheduling,<sup>110</sup> increasing the use of volunteer medical staff, narrowing the catchment area from which they will provide uncompensated care, increasing client cost-sharing, asking medical staff to work longer hours to add the necessary volume to make up for lost revenue, and cutting social service and administrative staff. While these strategies have allowed safety net providers to continue to deliver core services, they have also frequently required providers to compromise in ways that can affect both their own sustainability and the effectiveness and responsiveness of the care they provide. For example, next day scheduling prohibits the ability of clients to plan care according to work or school schedules. Use of physician volunteers means it is unlikely clients will see the same provider, which impedes continuity of care and the development of a productive relationship with the clinician. Asking medical staff to work longer hours increases the risk of medical staff turnover.

Interviews also indicated that many safety net providers are affected by low numbers of private physicians willing to accept Medicaid reimbursement. Almost all of the safety net providers with whom we spoke emphasized that few private physicians participate in the Missouri Medicaid program because of the low rate of Medicaid reimbursement and that the lack of private physicians participating in the Medicaid program strains the capacity of safety net providers. There was general consensus that the only physicians who can afford to treat Medicaid clients are those that work in institutions that receive some form of local, state, or federal subsidy (e.g., hospitals, FQHCs, or practices associated with a medical school). The situation is particularly problematic for clinics and facilities who primarily serve the uninsured, since these clinics rarely

participate in the Medicaid program and therefore cannot get reimbursed for the cost of providing care to clients who seek services at their facilities because they cannot find a private physician who will accept Medicaid.

Finally, the safety net providers interviewed acknowledged the significant challenges and costs associated with caring for individuals with disabilities and chronic illnesses. Many expressed the belief that meaningful solutions to health care reform must specifically address how to develop sound clinical and cost-effective models for meeting the needs of these populations.

### ***Input on Medicaid Reform Concepts***

#### **MANAGED CARE EXPANSION**

The providers who operate within Missouri's managed care corridor consistently cited the high variation in practices in the current managed care system, both from one MCO to another and even within the same MCO. This inconsistency makes prescribing treatment and managing care difficult. As a result, many interviewees expressed concerns that expanding managed care, either to new geographic areas or new populations, would impede safety net providers' ability to offer effective care and could increase their costs of providing care. Particularly among providers who serve a significant number of people with disabilities or with chronic conditions, concerns were raised about the ability of MCOs to effectively serve people with LTC health needs. These providers emphasized the need to ensure that plans to expand managed care to the ABD population should be structured to ensure that participating MCOs would have the necessary expertise and knowledge to competently serve people with disabilities. Stakeholders also cautioned that managed care would be unlikely to resolve, and could even exacerbate, problems associated with access to certain types of providers (e.g., mental health practitioners), which are not adequately available in many parts of the state.

Even among those providers who saw potential for managed care to improve access and quality of care, they believe that public policy makers' expectations should be in line with reality. In fact they stated that no matter how much emphasis is put on prevention and care coordination the system will still need to provide care to those with chronic illnesses and disabilities. Many of the providers interviewed view managed care, *if* designed and implemented carefully, as offering the potential to emphasize prevention and act as a vehicle for developing improved strategies for treating and managing chronic diseases (e.g., disease management or care coordination). As one

interviewee noted, the “goal of managed care expansion should be to create a system that promotes health as opposed to just managing how care is delivered.”

#### LIMITED OR TAILORED BENEFITS

Interviewees consistently voiced their belief that the use of limited or tailored benefit packages would need to be both carefully designed and based on sound clinical expertise in order to ensure that they are effective and avoid unintended consequences. For example, one interviewee noted the link between heart disease and gum disease, and cautioned that plans which did not include dental benefit could have the unintended consequence of potentially increasing the risk of heart disease. Others cautioned that it can be easy to view certain benefits (e.g. dental or mental health) as non essential, when in fact their absence can lead to increased use of services such as physician visits or hospital care, which are likely to be included as benefits in even the most limited plan.

In many cases, the individuals interviewed noted that their perspective on this approach had been influenced, to some degree, by their experience in providing services to Medicaid clients after the recent Medicaid cuts. In particular, some interviewees said that the cuts appeared, in some areas, to be leading to unanticipated and negative outcomes. For example, one interviewee noted that as a result of cuts to physical therapy benefits, practitioners treating Medicaid clients for back pain had fewer treatment options, the result of which appeared to be an increase in prescriptions for pain killers, some of which are narcotics. Overall, the individuals interviewed consistently highlighted the need for this type of approach to be carefully designed to protect against unintended consequences both in terms of how care is delivered and how much it ultimately costs.

#### COST-SHARING

Interviewees expressed a broad range of perspectives related to cost-sharing. While most, but certainly not all, of the safety net providers had experience with applying cost-sharing to the populations they serve, both their experiences and perceptions led them to different conclusions about the ability of cost-sharing to lead to greater compliance or involvement by consumers. Some interviewees’ experiences indicated that imposing cost-sharing requirements did encourage patients to take greater responsibility for their care. However, others said that their experiences showed that co-pays are a less than precise instrument in attempts to change patient behavior, noting that the factors contributing to noncompliance or unhealthy behaviors are often multi-faceted and often beyond the patient’s control. Some providers interviewed said that in their

experience, the most significant factor in encouraging responsibility/consumer involvement is building a strong relationship between provider and patient and creating an environment that meets the client's needs.

Many interviewees also said that their experiences with Medicaid co-payment requirements had indicated that co-payments are typically hard to collect and in effect become a reduction in providers' reimbursement, since "most Medicaid enrollees do not have the financial means to pay cost-sharing and most providers will continue to deliver the care," even if permitted to require cost-sharing. Additionally, some providers indicated that in their experience cost-sharing requirements for the Medicaid population usually leads to some patients delaying or forgoing care. Finally, many of the interviewees indicated that their experience showed that cost-sharing had the greatest likelihood of encouraging patients to use appropriate care when applied strategically (i.e. exempting preventative and/or clinic based services and requiring cost-sharing for ER visits).

#### HEALTHY BEHAVIOR INCENTIVES

Most interviewees noted that in their experience, changing patients' health behavior is challenging and usually requires concerted and well researched efforts. Additionally, most interviewees expressed concerns about how patient behavior would be tracked, and noted that if medical practitioners were expected to monitor behavior, that this could be both an additional burden on providers and could also lead to medical providers having to assume conflicting roles of both patient advocate as well as enforcer. For example, one interviewee wondered whether developing incentives based on patients quitting smoking would require the provider to verify that with nicotine blood tests.

Interviewees also noted that the way in which Medicaid reimburses providers for the time associated with encouraging and managing incentive programs will be important. Private Medicaid providers not affiliated with large practices or institutions typically do not have sufficient administrative or social services staff to support encouraging or monitoring health behavior incentives. There was broad consensus among those interviewed that incentives would need to be powerful enough to overcome the historic challenges in changing patient behavior. At the same time, most interviewees also cautioned that unintended consequences can result when basic health care services are conditioned upon certain behaviors. Almost all of the interviewees

stated that these programs should be developed based on clinical research and experience, particularly experience taken from providing care to low-income populations.

Interviewees consistently cited the need for incentives to be linked to what people really want. A number of interviewees noted that dental care could be a powerful incentive, since most adults on Medicaid need some level of dental work, but very few have the means to afford it. They also noted that dental care provided an example of a benefit that could be both a strong incentive and has solid underlying clinical and cost benefits, since good dental care can improve patients' nutrition habits and self confidence, and appears to be linked to reductions in the risk of heart disease and stroke. Finally, some of the interviewees suggested that developing this approach should include consumer input in determining what type of incentives would be most likely to change or alter patient behavior.

## **IMPACT OF MANAGED CARE ON THE ABD POPULATION: FOCUS ON SIX STATES**

Medicaid managed care models for persons with disabilities and the elderly are as unique in each state as the Medicaid programs themselves. Broadly defined, states are implementing fully capitated programs with public and private HMOs and/or non-capitated PCCM systems. Within those two broad categories there are multiple variations on each model depending on the state's Medicaid program structure, political interests, and managed care program goals.

For this review, Medicaid managed care models in six states were examined. Variations exist throughout the models, including target populations, the benefits included in the capitation program, and whether enrollment is mandatory or voluntary. For each model, examinations were made of performance indicators and special quality studies conducted by states to measure the outcomes of the programs. The performance indicators and quality studies included in this review were chosen because they provide information about how the various models have affected both traditional safety net providers and Medicaid enrollees.

### **Description of States' Programs**

While these states operate a variety of Medicaid programs, pilots, and demonstrations; the following programs were selected for review:

- Arizona Long-Term Care System (ALTCS) (managed LTC)
- Florida HMO (non-reform managed care)
- Florida Medi-Pass (PCCM)
- Minnesota Senior Health Options (MSHO) and Disability Health Options (MnDHO) (managed Medicare/Medicaid integrated program)
- North Carolina ACCESS (PCCM)
- Community Care Network of North Carolina (CCNC) (enhanced PCCM)
- Texas STAR+PLUS (integrated acute and LTC)
- Wisconsin Family Care (managed LTC).

These examples were chosen in part because they demonstrate the range of models that are found in Medicaid managed care programs for the elderly and people with disabilities. Following are brief descriptions of each of these programs.

## **Arizona**

ALTCS began in December 1988 for members with developmental disabilities and in January 1989 for elderly members and those with physical disabilities. It is administered as a distinct program from the “traditional” managed acute care program in Arizona. As of October 2005, close to 41,655 were enrolled in the ALTCS program. Approximately 68 percent of the clients served by the state’s Division of Developmental Disabilities are also covered under the ALTCS.

Eligibility determinations for ALTCS include both a financial and a medical/functional screen. Financial eligibility is extended to those with incomes up to 300 percent of SSI. Once financial eligibility has been determined, a medical/functional screen or preadmission screening (PAS) instrument is administered by the state. This is designed to allow only applicants who are at immediate risk of institutionalization into the ALTCS program. (However, current ALTCS beneficiaries who fail the PAS at the time of redetermination are eligible to continue receiving services through the ALTCS Transitional Program, a pilot program that was made permanent on October 1, 1997.)

Benefits covered under ALTCS include acute care services, as well as nursing facility services, ICF-MR services, case management, behavioral health services, and home and community based services. HCBS covered by ALTCS include home health care, homemaker services, personal care, adult day health, hospice, respite care, transportation, attendant care, environmental modification, life line alert, and home-delivered meals. Habilitation and day-care services are also covered for the developmental disabilities population.

Behavioral health services provided are primarily outpatient. They include individual and group therapy and counseling, emergency crisis behavioral health care, partial care, psychotropic medications, behavior management, and psychosocial rehabilitation. Inpatient psychiatric hospital services are available for persons under 21 years of age and Institution for Mental Disease services are available for members 65 years of age and older. For adults 21 through 64, behavioral health services are covered in three types of inpatient facilities: psychiatric health facilities, detox facilities, and crisis stabilization facilities.

The ALTCS program is managed by the Arizona Health Care Cost Containment System (AHCCCS, which is Arizona’s Medicaid program) through seven program contractors who are responsible for the ALTCS delivery system for elders and persons with physical disabilities. The

Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) is the contractor for the ALTCS delivery system for persons with MR/DD. Program contractors are responsible for providing all acute care services covered under AHCCCS to LTC eligibles and they are paid a capitation rate for each enrollee. Persons eligible for ALTCS are enrolled with a Program Contractor and select a PCP.

### ***Florida MediPass and HMO***

The Florida Medicaid program serves approximately 2.2 million people, with about half of those being children and adolescents under the age of 21. Estimated expenditures for state fiscal year 2006-07 are approximately \$15.9 billion. Florida is implementing a wide range of models and demonstrations. For purposes of this study, focus was placed on the MediPass PCCM Program and the HMO model.

Florida law mandates that Medicaid recipients must enroll with a managed care provider unless they have Medicare, are in a nursing facility, or are enrolled in certain special Medicaid waiver programs. The Medicaid managed care options that are available include:

- PCCM program (MediPass) or an EPCCM program;
- HMOs or Provider Service Networks (PSNs); and
- Children's Medical Services (a network for children with special health care needs).

Florida is currently engaged in implementing Medicaid reform through a section 1115 demonstration approved by CMS. This program seeks to enroll most recipients into capitated, risk-based health plans statewide and eventually to encompass most or all services, including LTC services (HCB and institutional).

### **PCCM PROGRAM - MEDIPASS**

MediPass is a PCCM program for Medicaid recipients developed and administered by Florida Medicaid since 1991. It is available statewide and is designed to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. MediPass providers receive a \$3.00 monthly case management fee for each of their enrolled patients, as well as the customary Medicaid reimbursement for all services rendered.

In MediPass, each participating Medicaid recipient selects or is assigned a health care provider who furnishes primary care services, 24-hour access to care and referral, and authorization for

specialty services and hospital care. MediPass PCPs are also responsible for referring the recipient for other necessary medical services on a 24-hour basis. PCPs are expected to monitor appropriateness of health care provided to their patients. In December 2006, over 474,000 recipients were enrolled in MediPass (excluding the EPCCM programs).

#### **EPCCM PROGRAM**

The EPCCM program was developed as a subcomponent of the MediPass program. Florida contracts with two MPNs and one pediatric ER diversion project to provide EPCCM services. Contractors are paid a \$3.00 case management fee for each Medicaid recipient enrolled during the month. They are also paid an advanced payment of up to \$12 monthly for each program enrollee as a part of a shared savings arrangement with the state. This advanced payment is in anticipation of the contractor's ability to control utilization of services. If the utilization of services is sufficiently controlled, the contractor and the state share in the program savings on a 50/50 basis. Reconciliation of the shared savings component is conducted twice a year. In December 2006, over 134,000 recipients were enrolled in the EPCCM program.

#### **FULL-RISK PLANS – HMOS AND PSNS**

Medicaid recipients also have the option of enrolling in HMOs or PSNs. Medicaid has contracted with HMOs since the mid-1980s for the full range of Medicaid acute care services. Medicaid HMOs must be licensed in Florida as commercial HMOs.

Florida also contracts with PSNs, which are networks established and operated by a health care provider, or group of affiliated health care providers. The health care providers must have a controlling interest in the governing body of the PSN organization. PSNs may be reimbursed on a FFS basis, but they are required to shift to a prepaid basis within four years of start-up. When they shift to payment on a prepaid basis, PSNs must meet the state's surplus and solvency requirements. December 2006 enrollment in the 65 non-Medicaid reform counties was 711,255 HMO recipients and 10,453 PSN recipients.

#### **MEDICAID REFORM**

Florida implemented Medicaid reform in Broward (Ft. Lauderdale) and Duval (Jacksonville) Counties in July 2006 and is now beginning in Clay, Baker, and Nassau Counties. One of the primary purposes of Florida's Medicaid Reform is to control expenditure growth by shifting from a defined set of Medicaid covered services to a defined contribution amount for each Medicaid recipient. During the initial phase, participation is mandatory for TANF and TANF-related

recipients and for the aged and disabled, including persons receiving SSI cash assistance and children eligible under SSI. The program is voluntary for individuals residing in institutions, children with chronic conditions, recipients with developmental disabilities, foster care children, pregnant women with incomes above the poverty level, and dual eligible recipients.

In the pilot counties, Medicaid recipients are provided two choices: HMOs or PSNs. As of December 2006, 57,446 recipients were enrolled in the HMOs and 49,427 recipients were enrolled in PSNs in the two Medicaid reform counties. Approximately, 16 percent of the enrolled population is ABD. MediPass and EPCCM enrollments have been phased out in the Medicaid reform counties.

### ***Minnesota Medicaid and Medicare Integration Models***

Minnesota operates two Medicaid/Medicare integration programs. MSHO was the first program. It was initiated in 1997 and targeted to seniors age 65 and older. The second program, MnDHO, began in 2001. Although both programs were designed to integrate Medicaid and Medicare, a person with Medicaid does not have to be enrolled in Medicare to participate in either programs.

#### **MSHO**

MSHO is a voluntary managed care program for seniors age 65 and older who are dually eligible for Medicaid and Medicare or who are eligible for Medicaid only and who live in one of ten counties in Minnesota. The goal of MSHO is to simplify Medicaid and Medicare financing and service delivery into a single program for individuals. This includes the integration of acute and LTC services, including 180 days of nursing facility services. The program is operated by three fully capitated HMOs who contract with the state for both Medicare and Medicaid services. The contract requires the health plan to assign a care coordinator to each enrollee. The care coordinator works to integrate both programs to meet the needs of the enrollee, including coordination of preventative, primary, acute, post acute, rehabilitation, and LTC services.

As of July 2004, total enrollment for MSHO was approximately 5,500. By January 2006, enrollment had reached 33,371.<sup>111</sup> The program began under Medicare 402 and Medicaid 1115 waivers. In May 2000, CMS granted approval for Medicaid state plan services to be provided under the authority of 1915(b) and 1915(c) of the Social Security Act rather than 1115. The health plans contracted for MSHO are both Medicaid and Medicare health plans.

## **MNDHO**

MnDHO was modeled after MSHO. It is a voluntary managed care program for working-age Medicaid-eligible beneficiaries with physical disabilities, who may or may not have Medicare coverage. The program is available to qualified individuals residing in one of seven counties in the Minneapolis-St. Paul area. This is a small program with approximately 534 enrollees as of January 2006, 58 percent of which are dually eligible for Medicare and Medicaid. Fifty-nine percent of enrollees live in the community and 51 percent reside in nursing facilities.<sup>112</sup>

All enrollees are matched with a health coordinator, to assist in navigating the health care system to access needed services. The enrollee and health coordinator work in equal partnership, developing a comprehensive health and preventative care plan with the goal of maintaining health and independence. The model was developed with strong consumer input (and consumer input remains a key element in program operations). For example, there is a consumer advisory committee and a consumer workgroup that focuses on design, implementation, and on-going program operations.

Prior to program implementation, an evaluation process was designed by stakeholders with the goals of measuring satisfaction, well-being of enrollees, and cost/utilization. In order to conduct a longitudinal study of enrollees, upon enrollment participants are asked a series of questions to document their experience in the FFS Medicaid program. One year later the same survey is administered to measure their experience in MnDHO. Results so far have indicated that 90 percent of the members report satisfaction with their health care services, as compared to 10 percent reporting satisfaction prior to enrollment.<sup>113</sup> In addition to the longitudinal survey, focus groups and other studies have been conducted to measure program performance.

In 1998, the state began discussions with CMS on MnDHO, and the three waivers were approved in 2001. Similar to the MSHO program, this program requires 1915(b), 1915(c) and 402 Medicare payment demonstration waivers.

## ***North Carolina ACCESS and Community Care of North Carolina (CCNC)***

The North Carolina Medicaid program serves approximately 1.5 million people annually, with just under 42 percent of those being children and adolescents under the age of 21. Expenditures for FY 2005-2006 were \$8.5 billion. North Carolina Medicaid managed care options that are available include:

- A PCCM program known as Carolina ACCESS; and
- CCNC, formerly known as ACCESS II and III, an EPCCM program.

Until July 2006, one county also had an HMO option.

ACCESS is a standard PCCM where beneficiaries are assigned to a participating PCP for oversight and their medical home. CCNC is an EPCCM program. It features an established network of providers and implementation of disease management programs (a number of which have now been evaluated). Although dual eligibles may voluntarily enroll in CCNC, ABD recipients are required to participate in CCNC. The networks must include case managers for individuals with complex needs. The networks are paid an enhanced administrative fee and utilize a physician incentive plan. As of December 2006, the fourteen CCNC plans had a combined enrollment of 745,863.

CCNC has implemented:

- Asthma disease management,
- CHF disease management,
- Diabetes disease management,
- ER initiatives,
- Pharmacy management initiatives, and
- Case management of high risk/high cost patients.

Initiatives under development include:

- ABD chronic care,
- Health choice,
- COPD disease management, and
- Enrollment of special needs children.

### ***Texas STAR+PLUS***

STAR+PLUS is a mandatory managed care delivery model designed to integrate acute and LTC services for SSI and SSI-related Medicaid adult beneficiaries. Children under the age of 21 may voluntarily join the program. The Texas Health and Human Services Commission (HHSC) is the Medicaid agency and operates the program. STAR+PLUS started in 1998 in Harris County (Houston), Texas. In December 2006, there were 73,887 members enrolled. The program is designed to better coordinate the care of persons with chronic and complex conditions. All

enrollees are assigned a care coordinator if needed or requested. The care coordinator is responsible for coordinating acute and LTC services and must be physically located in the service area. The HMO is responsible for all community based LTC services and the first four months of nursing home care. After four months of continuous nursing home care, the member returns to FFS.

This program requires both 1915(b) and 1915(c) waivers from the federal government. The 1915(b) waiver allows HHSC to limit the number of health care providers available to clients and to require that certain Medicaid clients participate in the managed care program. The 1915(c) waiver allows HHSC to provide HCBS such as adult day care or attendant care to Medicaid recipients who would otherwise require nursing home or other forms of institutionalized care. The waiver authority also permits HHSC to offer STAR+PLUS in selected areas of the state rather than on a statewide basis. The current program is operated by two for-profit health plans.

HHSC has an expansion plan underway to operate STAR+PLUS in four other major metropolitan areas starting February 1, 2007. After the expansion is complete, STAR+PLUS will include approximately 140,000 mandatory adults age 21 and older and 40,000 voluntary eligibles under the age of 21.<sup>114</sup> However, the expanded model will be reconfigured from the current model. Due to potential loss of UPL funds, HHSC submitted a redesigned 1915(b) waiver that excludes inpatient hospital services. All inpatient hospital services will remain in the FFS system. The HMO will still be responsible for coordinating all care, including inpatient hospital services, and will continue to authorize and provide utilization management services related to inpatient care.

In addition to STAR+PLUS, Texas operates a PCCM program in the non-urban counties in Texas. This program is for pregnant women, children, and SSI recipients. It is not an integrated program, but is instead a traditional PCCM program coordinating only Medicaid acute care services. The program promotes a medical home through a PCP and provides a disease management program to members who have certain diseases.

### ***Wisconsin Family Care***

Family Care is a managed LTC program operating in five Wisconsin counties and serving three target populations: frail elderly individuals and adults with physical or developmental disabilities. Family Care has two major organizational components:

- Aging and Disability Resource Centers offers information, assistance and a limited number of services for the elderly, persons with disabilities, and their families. They also serve as a clearinghouse for information on LTC for physicians, hospital discharge planners, and others.
- Care Management Organizations (CMOs) manage and deliver a wide variety of covered LTC services under the Family Care benefit. CMOs develop and manage a comprehensive set of LTC services and supports, either by providing the service with CMO staff or by purchasing the service from other providers. Each CMO receives a risk-adjusted monthly capitation payment for each enrollee and is at-risk for the full range of institutional and home and community based LTC services provided under the Family Care benefit.

The program operates under two 1915(b) and two 1915(c) waivers that allow the state to limit the provision of LTC services in the five counties to individuals enrolled in a CMO, and allow the state to provide HCBS, in lieu of institutional services, for individuals with LTC needs that would qualify for nursing facility or ICF/MR care. CMS approved the initial Family Care waivers in 2001. The program is now in its first renewal period, which runs through 2009.

Family Care currently serves 9,915 people in the five counties. In May 2006, Governor Doyle signed legislation to expand the program statewide within five years, and in July 2006 the state awarded planning grants to organizations to establish the necessary framework in all but the northernmost portions of the state.

## **Key Factors Related to Cost, Quality, and Access**

As states look to enroll all or part of their ABD populations into managed care, questions arise as to whether these efforts are successful and which design elements contribute to their success. A variety of indicators were identified that are key to understanding the success of these models of Medicaid managed care that have been implemented in other states. These indicators were selected because they answer important questions about how the various models have impacted enrollees and safety net providers. The indicators include:

- Access to services/choice of providers,
- Access to HCBS,
- Disease management/health outcomes,
- Use of preventative care,
- Personal outcome measures,
- Consumer satisfaction,

- Provider satisfaction,
- Inpatient hospitalization rates,
- ER utilization rates, and
- Prevention of institutionalization.

These factors fall into four major domains: cost, quality, access, and satisfaction. While not all of the six states reviewed addressed every indicator, information has been provided where it is available. Table 12 shows the major indicators and states that addressed these indicators, grouped by domain.

<b>Table 12. A Review of Indicators in Six States, by Domain</b>		
<b>Domain</b>	<b>Indicator</b>	<b>States Measuring</b>
<b>Access</b>		
	Access to services/choice of providers	AZ, FL, TX
	Access to home and community based services	WI
<b>Quality</b>		
	Disease management/health outcomes	AZ, TX
	Use of preventative care	MN, WI
	Personal outcome measures	WI
<b>Satisfaction</b>		
	Consumer satisfaction	AZ, FL, MN, NC, TX, WI
	Provider satisfaction	TX
<b>Cost</b>		
	Inpatient hospitalization rates	NC, TX, WI
	ER utilization rates	FL, NC, NM, TX, WI
	Prevention of institutionalization	AZ, FL, WI

### **Access**

Among the major drivers of the interest in managed care for the ABD population is improving access to care for this vulnerable population. Issues of access are also among the biggest concerns cited by stakeholders in considering such a move.

### **FEDERAL REQUIREMENTS FOR ACCESS IN MEDICAID MANAGED CARE**

The federal BBA requires states to guarantee a certain level of access to services and providers for all managed care enrollees.<sup>115</sup> In addition, through its contracts with MCOs, the state must ensure the delivery network meets a series of federal requirements related to access such as sufficient geographic coverage of providers, physical access for persons with disabilities, ability of members to receive a second opinion, and 24 hours a day/7 days a week availability of

services, when medically necessary. (See Appendix B for a complete list of the federal requirements.)

## STATE SPECIFIC OUTCOMES FOR ACCESS

States create performance standards in their HMO contracts specifying access requirements, such as timeliness of appointments and geographic requirements for the managed care network. A national study commissioned by the California Association of Health Plans –“Medicaid Managed Care - The Impact of Enrolling ABD Beneficiaries: A National Review of Programs” was completed by the Pacific Health Policy Group in March 2005. The study reviewed research specific to enrollment of ABD recipients in capitated managed care programs in twelve states, four of which (Arizona, Florida, Minnesota and Texas), were also included in our focus.

The report noted the following in regard to access:<sup>116</sup>

- States frequently include within their contractual requirements of managed care plans protections to ensure that persons with disabilities and chronic medical conditions have appropriate access to specialty care.
- Access to specialist care is improved for many enrollees, as the managed care plans are often able to recruit specialists into their networks that had refused to participate in the Medicaid FFS system.
- About three-quarters (75 percent) of STAR+PLUS survey respondents reported that they were “always” or “usually” able to access care promptly. Over 93 percent of dually eligible and approximately 66 percent of Medicaid-only members reported that it was easy to get a care coordinator to assist them. The majority of respondents also said that it was a relatively simple matter to arrange LTC services like attendant care as well as special equipment and therapies.

Access outcome data provides some comparisons between various health care arrangements implemented in the Florida Medicaid program. These data do not include Florida’s recently implemented Medicaid reform program. The programs evaluated represent FFS, MediPass PCCM, MPNs (i.e., EPCCM programs that include a shared savings arrangement with the state), PSNs (that also have a shared savings arrangement with the state), and full-risk HMOs. Findings include:

- Recipients reporting a usual source of care: This outcome is consistently positive across enrollment arrangements ranging from a low of 71.4 percent for PSNs to a high of 82.3 percent for FFS recipients.

- Ease finding a satisfactory PCP: 78 percent of FFS and PSN enrollees reported it was “not a problem” to find a PCP. Among the HMO, MediPass and MPN groups, 64-69 percent reported it was “not a problem” to find a satisfactory PCP.
- Difficulty seeing a specialist: Not surprisingly, over 76 percent of FFS enrollees reported they had no problem seeing a specialist while 52 percent of HMO enrollees and 64 percent of PSN enrollees reported it was not a problem. This measure cannot necessarily be interpreted to reflect a problem with access as it might reflect the impact of “managing care” appropriately.
- Access to urgent care: PSNs scored most favorably with over 75 percent of enrollees reporting that they “Got Immediate Care for Illness or Injury as Soon as Wanted.” Fifty-five percent of HMO enrollees reported favorably for this measure.
- Self-reported ER visits did not vary significantly by type of enrollment arrangement. However, self-reporting could be inaccurate due to lack of recall regarding specific events by the respondent.
- There were also no significant differences reported by enrollees in various arrangements in regards to accessing care, tests, and treatments.<sup>117</sup>

Access to community-based LTC services has been favorably impacted by managed care programs designed to include both acute and LTC services. Community-based LTC services are less expensive and maintain members in their home rather than in high cost institutional settings. In a fully capitated model, these services decrease the overall cost of care, therefore providing an incentive for HMOs to focus on the use of these services. In the acute and LTC integrated programs reviewed, access to HCBS increased. Specific findings include:

- When Wisconsin implemented Family Care the state made Family Care services an entitlement. Previously, HCBS were capped under traditional HCBS waivers.
- In Florida, Nursing Home Diversion Waiver providers must have a complete network of at least two providers for each service component under the program (e.g., personal care). This provider network requirement appears to have provided greater access to HCBS.
- In addition, because Nursing Home Diversion waiver providers are at-risk for nursing facility care, enrollees have a higher use of HCBS versus nursing facility services than do enrollees in non-managed HCBS waiver programs.
- In Texas STAR+PLUS, Personal Assistance Services were 32 percent higher than the projected FFS level for 1999. Community Based Alternatives increased 119 percent in the STAR+PLUS service area compared to a 3.4 percent increase statewide.<sup>118</sup>

## IMPACT OF MEDICAID MANAGED CARE ON ACCESS FOR THE UNINSURED

An article published in *Health Affairs* in 2005 evaluated the relationship between Medicaid managed care and access for the uninsured was examined over an eight-year (1994-2001) period

using county-level data on a nationwide sample. The study was examining the impact of increasing Medicaid managed care enrollment on access to the care for the uninsured.

The study examined access using three components: care was delayed due to cost in the past year; needed care was not obtained due to cost in the last year; and whether or not the individual had a usual source of care. It was assumed these measures would change if there had been a significant impact on the ability of safety net providers to continue to serve the uninsured when Medicaid managed care was implemented.

The authors acknowledge that there have been previous studies that rightly led to concern about the impact of Medicaid managed care on care for the uninsured; however the authors suggest the statistical strength of this study's data outweighs the more narrowly defined studies that were previously conducted. The authors suggest that safety net providers are coping with the changes associated with Medicaid managed care. Providers may have developed strategies to provide access to care despite potential difficulties. Also, state policies aimed at protecting the safety net with the implementation of managed care may have played a role in limiting any negative impacts on the safety net. For example, some states require Medicaid managed care plans to contract favorably with safety net providers or provided incentives for such contracts through favorable auto-assignment of patients or allowing and encouraging providers to sponsor their own plans. Many states have also maintained cost-based reimbursement for some safety net providers.<sup>119</sup>

### ***Quality***

When considering moving to a managed care delivery system, quality of care is often one of the driving factors cited by states, along with cost-savings, cost predictability, and access. States often believe that MCOs are better equipped to manage care and coordinate a complex array of services, especially for the vulnerable ABD population. Indeed, while managed care programs for the ABD population have developed more slowly than programs for the TANF and TANF-related populations, managed care plans have developed numerous special programs and initiatives aimed at improving clinical care and outcomes for ABD enrollees.<sup>120</sup>

At the same time, advocates are often strongly opposed to managed care for the ABD population, citing access and quality concerns. These sometimes conflicting views highlight the need for

developing managed care programs that are structured around clearly articulated and measurable goals in the areas of quality of care, patient outcomes, and access to services.

The BBA gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans and also required the establishment of consumer protections for Medicaid managed care enrollees in areas such as access to and quality of care.<sup>121</sup> In June 2002, CMS issued final regulations for Medicaid MCOs to implement these BBA requirements.<sup>122</sup> These regulations impose a number of requirements on managed care programs that are not present in traditional FFS Medicaid.

Specifically:

- State Medicaid programs are required to include in their managed care contracts standards for quality measurement and improvement and procedures for assessing the quality of care of Medicaid managed care enrollees;
- States must require MCOs to meet minimum performance levels on standardized measures and conduct performance improvement projects; and
- States must conduct annual external quality reviews of MCOs to validate performance data and review plans' quality assurance programs and performance improvement projects.

In addition, many states have conducted independent assessments of their managed care programs, or specific aspects (e.g., disease management initiatives) of their managed care programs, to gain additional insights on issues related to quality, access, and cost-effectiveness. Many states have also built additional requirements into their managed care contracts (e.g., the provision of disease management programs for specific conditions) as another means of ensuring and improving the quality of care for enrollees.

Within the federal guidelines outlined above, states have great flexibility in structuring their quality assurance activities. For example, many states require MCOs to collect and report some or all of the national Health Plan Employer and Data Information Set (HEDIS) measures,<sup>123</sup> or a set of HEDIS-like measures. Other states have developed their own set of indicators to measure quality. For example, early in the development of its Family Care managed LTC program, the Wisconsin Department of Health and Family Services (working with consumers, providers, and advocates) developed a set of 14 "member outcomes" centered on each individual's quality of life. Each year the Department conducts interviews with randomly selected Family Care members to measure progress against these 14 measures.

In addition, many states have developed and track indicators on the use of preventive care, including immunization rates and PCP office visits, as an indicator of quality of care.

The programs reviewed indicated generally favorable results with respect to quality of care and member outcomes. However, it is important to note that states employ a variety of baselines and comparison groups in their measurements. Therefore, direct comparisons across programs are not possible. A recent review of Medicaid managed LTC initiatives conducted by AARP found that these programs have a “neutral to favorable” impact on quality.<sup>124</sup> Below are summaries of Medicaid managed care’s impact on quality in the six key states.

#### ARIZONA LONG-TERM CARE SYSTEM

A focused study on diabetes management within the ALTCS program found that outcomes on three HEDIS measures for diabetes care far exceeded program goals. Another study was conducted that looked at performance measures for ALTCS members’ influenza and pneumococcal vaccination rates. This study showed increased rates of vaccinations over the previous year for individuals in HCB settings and nursing facilities.<sup>125, 126</sup>

#### MSHO

HEDIS data (2002) indicate mixed results on several key measures applicable to the ABD population.<sup>127</sup> On controlling blood pressures, MSHO enrollees were near the national Medicare+Choice (now Medicare Advantage) rate despite having a more intensive case mix. Several measures related to diabetes care indicated room for improvement within MSHO, prompting health plans to initiate an additional quality improvement project on diabetes in 2003. Specifically, eye exams for people with diabetes were near the national rate, with minimal change over a four-year period. Cholesterol screenings were below the national Medicare+Choice rate but improving. HBA1c control rates were double the national Medicare+Choice rate (for this measure a lower score shows better control of diabetes).

In addition, an independent evaluation of the MSHO program<sup>128</sup> found that:

- There was no difference in overall death rates for either community or nursing home groups;
- MSHO had significantly fewer short stay (30 days or less) nursing home admissions than either control group;

- There was no difference between groups in rates of nursing home discharge (successful discharge in that the individual was alive upon discharge and for up to one month following discharge) for nursing home stays less than 30 days. MSHO had significantly greater rates of discharge at less than 60 days compared to both groups. MSHO had a significantly lower rate of discharge from nursing homes greater than 60 days; and
- Quality indicators, using the national Minimum Data Set (MDS), for nursing home residents were comparable for MSHO and the two control groups.

#### **CCNC, ACCESS, & HMO**

HEDIS data for 2005 indicate that rates of recommended preventive services were higher in the CCNC program than in the HMO or FFS programs. However, the state notes that the HMO data rely on encounter data, and rates may be underreported due to the complexity of the encounter data submissions. In addition, CCNC's disease management projects report that over 90 percent of staged asthma patients received appropriate preventive medication.

#### **TEXAS STAR+PLUS**

STAR+PLUS MCOs are required to have disease management programs in place for asthma, CAD, CHF, COPD, and diabetes. STAR+PLUS enrollees with CAD report similar results for blood pressure control as the mean results for MCOs reporting this HEDIS measure nationwide. However, only one-third of STAR+PLUS enrollees with diabetes have good metabolic control (based on HBA1c) compared to 51 percent nationally.<sup>129</sup>

#### **WISCONSIN FAMILY CARE**

The Wisconsin Department of Health and Family Services interviews randomly selected Family Care members annually to measure progress on 14 "personal outcome measures." Trained interviewers conduct structured conversations with the members to determine whether each of these outcomes is present in the member's life, and then conduct structured interviews with the member's care manager to determine whether support was present for achievement of each outcome.

**Table 13. Wisconsin Family Care Member Personal Outcomes**

Foundations

1. People are safe.
2. People have the best possible health.
3. People are free from abuse and neglect.
4. People experience continuity and security.

Community Integration Outcomes

5. People choose where and with whom to live.
6. People participate in the life of the community.
7. People remain connected to informal supports.

Self-Determination and Choice Outcomes

8. People are treated fairly.
9. People have privacy.
10. People have their personal dignity and respect.
11. People choose their services.
12. People choose their daily routines.
13. People achieve their objectives.
14. People are satisfied with services.

The Department has not yet identified benchmarks or targets for these outcome measures. At the local level, each CMO is required to have an internal quality management and improvement program that collects and reports information on undesired member outcome measures, identifies people who do not achieve desired outcomes, and allows the CMO continuously to monitor and evaluate its own performance and that of its providers.

The table below provides summary data on the 14 outcome measures across all participating populations and sites over the two most recent evaluation cycles for which data are available. The data indicate an upward trend in achieving the desired outcome across almost all measures.

**Table 14.**

Family Care – All Members	Outcomes Present				Supports Present			
	Outcomes found to be present for the 501 members who were interviewed.				Supports found to be present for the 501 members who were interviewed.			
	Round 3 (2003)		Round 4 (03-04)		Round 3 (2003)		Round 4 (03-04)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<b>Foundations</b>								
People are safe.	346	70.5%	406	81.0%	330	67.2%	415	82.8%
People have the best possible health.	272	55.4%	340	67.9%	303	61.7%	419	83.6%
People are free from abuse and neglect.	423	86.2%	443	88.4%	364	74.1%	236	47.1%
People experience continuity and security.	279	56.8%	274	54.7%	267	54.4%	292	58.3%
<b>Community Integration</b>								
People choose where and with whom to live.	277	56.4%	327	65.3%	248	50.5%	340	67.9%
People participate in the community.	275	56.0%	324	64.7%	283	57.6%	315	62.9%
People remain connected to informal supports	320	45.4%	388	57.7%	312	63.5%	429	85.6%
<b>Self-determination and choice</b>								
People are treated fairly.	362	73.7%	391	78.0%	348	70.9%	265	52.9%
People have privacy.	447	91.0%	446	89.0%	409	83.3%	429	85.6%
People have personal dignity and respect.	355	72.3%	387	77.2%	357	72.7%	326	65.1%
People choose their services.	223	45.4%	289	57.7%	212	43.2%	356	71.1%
People choose their daily routines.	361	73.5%	399	79.6%	350	71.3%	426	85.0%
People achieve their employment objectives.	285	58.0%	323	64.5%	259	52.7%	329	65.7%
People are satisfied with services.	350	71.3%	388	77.4%	349	71.1%	423	84.4%

Source: Family Care Quality; CMO Member Outcomes: Round 3 and Round 4 data. Wisconsin Department of Health and Family Services, Division of Disability and Elder Services

**Impact of Managed Care on Use of Preventive Care – State Examples**

**MSHO**

The results of an independent evaluation indicate that MSHO community enrollees have higher rates of pneumococcal and influenza immunizations than the control group, as well as higher rates of pap smears, occult blood tests and prostate cancer screenings. Nursing facility enrollees are less likely than the control group to receive pneumococcal immunizations but more likely to receive influenza immunizations. They also have higher rates of pap smears, prostate cancer screenings, and glaucoma screenings relative to the control group, but receive fewer mammograms.<sup>130</sup>

**WISCONSIN FAMILY CARE**

Across all counties and target groups, Family Care members meet with their PCPs more often than their comparison group counterparts.<sup>131</sup> This pattern remains constant when the effects of other variables, such as gender, functional status, geographic location, and dual eligibility are considered, implying that the design of Family Care significantly increases the number of primary care visits over LTC provided in non-Family Care counties.

## **Satisfaction Indicators**

### **CONSUMER SATISFACTION**

Program satisfaction, for both consumers and providers, is a key component to a successful managed care program. Unlike most FFS programs, states have consistently tracked consumer satisfaction in managed care programs. Since this is not typically done in FFS, it is difficult to gauge how much satisfaction has changed as a result of managed care but it does give an assessment of the current satisfaction levels of managed care enrollees and gives feedback to states and HMOs on the status of satisfaction over time.

States reviewed for this study require their MCOs to conduct special studies related to consumer satisfaction and/or participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey. Although CAHPS was not specifically designed to measure satisfaction for people with disabilities, it does provide a measure of satisfaction in categories such as getting needed care, getting needed care quickly, getting needed care without long waits, satisfaction with physician advice, and health plan customer service.

Overall indicators in the state programs reviewed suggest positive satisfaction level by consumers in managed care programs. Individual states' experience with measuring consumer satisfaction within managed care is described below.

#### North Carolina

According to the Division of Medical Assistance, overall satisfaction was high across all delivery modes. The mean satisfaction ratings for all aspects of health care delivery ranged from 8.93 to 9.21 with 10 being the most favorable score. In North Carolina's ACCESS program, the chronic group registered higher satisfaction than the non-chronic group. The only area in which there were significant differences between the delivery modes was in waiting times to see a physician. Respondents in the HMO were more likely to report a wait of more than 15 minutes past an appointment time to receive care.<sup>132</sup>

#### Arizona

A consumer satisfaction survey was conducted of ALTCS members and their proxies on satisfaction with their case manager, HCBS, nursing facility, and doctor. Data from a 2002 LTC Project Consumer Satisfaction Survey, shows high program satisfaction for consumers in the ALTCS program.

The results included:

Satisfaction with case management	93%
Satisfaction with providers	91%
Satisfaction with HCBS	95%
Satisfaction with nursing facilities	93%

### Wisconsin

Satisfaction with services improved in the Family Care Program in 2005-06 compared to 2003. The External Quality Reviewer report found that 76.4 percent of members were satisfied with their services in 2005-2006 compared to 71.7 percent in 2003. The same report found 83.4 percent of members had necessary supports in place compared to 72.7 percent in 2003.

### Florida

Two studies, one in 2001 and one in 2004, measured client satisfaction in the two managed care programs in Florida. In 2001, Nursing Home Diversion Waiver (managed LTC) clients were found to be generally more satisfied with the programs than with the traditional Medicaid HCBS waiver.<sup>133</sup> In 2004, the University of Florida measured involvement in health care decision making for Medicaid HMO enrollees, which has been found to be positively correlated with patient satisfaction. When asked how often they were involved in their health care decision making, most Medicaid enrollees surveyed (86%) said that they were “usually” or “always” involved. Among Medicaid program components, there was no significant difference on this measure. Enrollees were also asked “how much of a problem, if any” they had in getting their health care providers to agree with them on the best way to manage their health care. Again, the vast majority of enrollees (80%) reported that it was “not a problem,” while 15 percent reported “a small problem” and 6 percent reported “a big problem.” There was no significant difference in the program components on this measure.<sup>134</sup>

### Minnesota

Minnesota Disability Health Options conducted surveys of members prior to enrollment and after enrollment to gauge satisfaction levels. According to the Center for Health Care Strategies, 90 percent of members report satisfaction with their health care services, as compared with 10 percent satisfaction prior to enrollment.<sup>135</sup>

## PROVIDER SATISFACTION

Provider satisfaction has also been measured in some of our identified states; however, not as consistently as consumer satisfaction. This is an area deserving of attention by states moving into a managed care service delivery system. Medicaid has traditionally had difficulty recruiting new providers and in the past few years, some states have had growing indications of fewer physicians, particularly specialists, participating in Medicaid. Gauging provider satisfaction and analyzing specific issues causing dissatisfaction can assist states in redesigning program elements, when feasible, to increase provider satisfaction.

A survey of physician satisfaction in Missouri was published in the *Journal of Family Practice* in January 2000. Overall the study found that of the physicians responding to the survey, 40 percent were satisfied with commercial managed care, 39.7 percent were satisfied with previous traditional Medicaid, and 28.6 percent were satisfied with Medicaid managed care. Although the traditional satisfaction among doctors in managed care was higher than satisfaction with Medicaid managed care, it was similar to the satisfaction of traditional Medicaid physicians' satisfaction with traditional Medicaid (29.8%). The authors of the study note the survey of PCPs measured provider satisfaction during the early stages of implementation of Medicaid managed care, which could have increased negative outcomes.

In the states analyzed, provider satisfaction was measured less often, and in fewer states, compared to member satisfaction. The Texas STAR+PLUS program and Florida's MPN program both reported data on provider satisfaction.

### Texas

In 1999, 2000, and 2001, the Texas External Quality Review Organization conducted provider satisfaction for STAR and STAR+PLUS. The results were not distinguished by program; however, the LTC providers are only in STAR+PLUS.

PCP and specialty providers were most satisfied with appropriate coverage for treatment and services (just over 50%) and appropriate coverage for health promotion and disease management (64% primary care, 49% specialists). PCPs and specialty providers were most dissatisfied (over half) with the amount of paperwork, amount of phone time, level of reimbursement, and the appeals process.

LTC providers were satisfied with clinical care, with the amount of paperwork (55%), with care coordination (43%), and with customer service (38%). The LTC providers were overwhelming dissatisfied with timeliness of claims payment (80%), adequacy of reimbursement (62.5%), and accuracy of claims payment (61%). These studies were conducted in the first years of the STAR+PLUS program and may or may not have improved over time if the studies had continued. Since they were not replicated after 2001, it is impossible to draw conclusions.

For these programs, a survey was also done of behavioral health providers to measure satisfaction with the managed care program. On a scale of 1-5, range of satisfaction was 2.16 to 3.16 reflecting moderate dissatisfaction to neutral feelings. Forty nine percent would recommend Medicaid managed care participation to a colleague, while 51 percent would not. There are some STAR+PLUS indicators specifically broken out but the sample size is too small to draw conclusions. For both programs, the majority of respondents felt Medicaid managed care had a negative impact on access to care, continuity of care, quality of care, and administrative costs.<sup>136</sup>

### Florida

A 2004 evaluation of Florida's MPN model (enhanced MediPass) reported general satisfaction among physicians in the program. The physicians reported elements such as monthly utilization reports, the physician incentive plan, and additional administrative support were improvements over the "traditional" MediPass PCCM program. In addition, MPNs rated this model as a positive alternative to the HMO model.<sup>137</sup>

## MEASURING SATISFACTION

Ideally, consumer and provider satisfaction in Medicaid would be surveyed before and after managed care implementation. This would provide a baseline of performance for states and health plans to use to determine success or needed improvement for managed care programs. States should consider what modifications can be made to standardized measurement practices in order to clearly identify the results for people with disabilities and the elderly. Once managed care is implemented, surveys should continue to monitor progress over time.

### **Cost**

The escalating cost of Medicaid services is a major reason that states pursue managed care strategies. Cost is of particular concern for the ABD population, because their needs consume significant amounts of states' Medicaid budgets and these populations tend to have complex needs. States typically expend a disproportionate share of the Medicaid budget on ABD

recipients: in 2005, 71 percent of the Medicaid budget purchased services for recipients who make up only 26 percent of enrollees.<sup>138</sup>

Many state Medicaid reform initiatives including those that seek to enroll Medicaid ABD individuals into some form of managed care (e.g., PCCM, disease management, and full-risk-based HMOs) desire to achieve cost-savings. States have sought ways to provide a medical home for Medicaid beneficiaries in order to provide more preventive care and reduce inpatient and ER visits. HMOs have traditionally been successful in reducing inpatient days in a previously unmanaged population. In recent years, some states have expanded these efforts by introducing managed LTC because of the growing cost for nursing home services and for the users of LTC services.

A Lewin review of fourteen studies specific to full-risk capitated Medicaid managed care found that the "...studies strongly suggest that the Medicaid managed care model typically yields cost savings. While percentage savings varied widely (from 2% to 19%), nearly all the studies demonstrated a savings from the managed care setting.

Second, the studies provide some evidence that Medicaid managed care savings could be significant for the SSI and SSI-related population. For example, in Arizona, 60 percent of the \$102.8 million savings achieved from 1983 to 1991 was from the SSI population. The Texas STAR+PLUS program, which focuses on SSI enrollees, achieved per member per month savings of \$4 in the first waiver period and \$92 in the second waiver period.<sup>139</sup>

The following discussion examines selected states data on inpatient hospitalizations, ER utilization, and attempts to control and prevent institutional care through the better use of other community alternatives. While there is no available state by state benchmark comparison of effectiveness, there is a substantial base of data and studies.

#### INPATIENT HOSPITALIZATION

Lewin's review of studies of Medicaid managed care in fourteen states found that "the studies demonstrated that states Medicaid managed care cost-savings are largely attributable to decreases in inpatient utilization." Among the Lewin study's specific findings is that in Texas' STAR+PLUS, inpatient stays have been lowered by 28 percent.<sup>140</sup>

A study of the proposed expansion of the Texas STAR+PLUS program projects a 28 percent reduction in inpatient costs, based upon data from the pilot of this program in the Houston area. Texas is now expanding the program with a modification to the original program based upon potential impact to the Medicaid UPL program.<sup>141</sup>

The Center for LTC Integration reported that the original evaluation of the Texas STAR+PLUS program found a decrease of inpatient use compared to the FFS population of 290.3 discharges per 1,000 member months vs. 329.7 under FFS. PACE program enrollees have also experienced a greatly reduced rate of inpatient days versus FFS enrollees (who are less frail than PACE enrollees).<sup>142</sup>

### North Carolina

A study of the CCNC reports that their asthma disease management program resulted in “23 percent fewer hospitalizations per 1,000 asthmatic CCNC (EPCCM) enrollees under the age of 21 than there were for ACCESS (“regular” PCCM) enrollees.” The report also found that “hospitalization was also lower for diabetic patients treated in the CCNC networks.” The annual rate of hospitalizations per 1,000 diabetic enrollees was lower in the CCNC over all three years of the study.<sup>143</sup>

### Wisconsin and Minnesota

The managed LTC programs, Wisconsin Family Care and Minnesota Senior Options, did not report any significant decrease in inpatient care.<sup>144</sup>

## ER UTILIZATION

The increasing utilization of ERs has posed a great challenge to the health care system, with a number of ERs closing and a greater demand for services fueled, in part, by the growing number of uninsured. The ER is the one place where a person cannot be denied care on the basis of ability to pay. Many states collect ER utilization data, but this data is not always available specific to Medicaid programs.

The Medicaid Managed LTC states have received favorable reports on ER utilization. In reviewing the states, the AARP Issues Brief (79) reported that Medicaid Managed LTC reduces the use of ERs, hospitals, and nursing homes. “One fairly clear outcome is that Medicaid Managed LTC, like private sector managed care, reduces the use of higher cost services, including ERs, hospitals, and nursing homes.”<sup>145</sup>

### Florida

The Florida Agency for Health Care Administration has reviewed ER visits (all payer sources and the uninsured) from 1994 to 2004 and found that visits increased by 40.9 percent while there was a decrease in the number of ERs. The data includes the reason for the visit, the demographics, and program type of visits. Almost 70 percent of visits were for persons under 45 years of age. The majority of visits had an acuity level of low to moderate, and Medicare accounted for the largest proportion of high-acuity visits. Among the most frequent principal diagnoses were upper respiratory infection, middle ear infection, and viral infection.<sup>146</sup>

Florida Medicaid data suggests that “medical homes” are being utilized by some recipients in a manner that avoids ER care. When Florida Medicaid recipients enrolled in the PCCM, PSN or HMO models they were asked if they received urgent care when they needed it. Sixty percent of Medicaid enrollees reported that they always got the care when they needed it, compared to national CAHPS reports, that found a national rate of 56 percent. The reports of the seven Medicaid plans differed significantly on this measure, with the PSN population reporting most favorably. Seventy-five percent of PSN enrollees reported that they “always” received care as soon as they wanted it.<sup>147</sup>

### North Carolina

North Carolina provides each CCNC provider with quarterly utilization reports and monthly ER and referral reports.

### Wisconsin

Wisconsin Family Care groups all showed greater percentage decreases in the rates of change specific to ER use over the study period than the comparison group counterparts (i.e., individuals with similar characteristics but not enrolled in Family Care).<sup>148</sup>

### Minnesota

The Minnesota Medicare/Medicaid LTC program is reported to have reduced the number of preventable ER visits.<sup>149</sup>

## PREVENTION OF INSTITUTIONALIZATION

Since 70 percent of state Medicaid budgetary expenditures are for people with disabilities and LTC needs, many states have focused on implementing reforms in this area. Such reforms include

expanding funding for the traditional Medicaid HCBS waivers and better intake and assessment programs. A number of states have also used managed LTC programs to permit MCOs more flexibility in the delivery and mix of services and to encourage the use of HCBS over traditional institutional services. Program data and evaluations have tried to capture the effect of the programs on the high cost institutional care component in the Medicaid budget. Of the states under study, Arizona, Florida, Minnesota, and Wisconsin have made significant efforts and have some data in this area.

The Center for Health Care Strategies has reported that “Managed LTC programs have been shown to improve quality, cost-effectiveness, and community placements in several states, including Arizona, Florida, Texas, and Wisconsin”.<sup>150</sup>

### Arizona

Arizona has provided Medicaid LTC services under the capitated managed care program, known as Arizona’s LTC Services Program (ALTCS). The program reports continual decreases in nursing home residency of ALTCS members from 58.8 percent in 1998 to 46.6 percent in 2002. ALTCS members have been increasingly served during the same time frame in the home (35.9% to 40.8%) and in alternative residential settings (5.2% to 12.5%).<sup>151</sup>

### Florida

The most recent study of Florida’s Nursing Home Diversion Waiver program found that the program delayed and reduced participants’ entry into nursing homes, a 12 percent probability for the program compared to 48 percent of the non-program group. The program participants also experienced shorter nursing home stays (43 days compared to 132 for the non-program group) and were more likely to return to their homes to continue program services.<sup>152</sup>

### Wisconsin

An independent assessment of the Wisconsin Family Care Program found that nursing home expenditures were significantly lower for the Family Care group than for the control group. These findings could indicate that Family Care is achieving program goals of greater diversion/deinstitutionalization, but could also indicate more favorable contract terms between care management organizations and nursing facilities.<sup>153</sup>

## **Recommendations for Baseline of Key Indicators for Assessing Impact of Medicaid Managed Care Expansion**

When states are considering the adoption of Medicaid managed care programs for people who are elderly and people with disabilities, it is important and challenging to determine the appropriate means to track the impact of programs. In the states reviewed, sometimes goals and measures were put in place pre-implementation and sometimes post-implementation. Often times what is measured and how it is measured changes over time making longitudinal studies on the impact of a specific managed care initiative more difficult to conduct.

In developing impact and performance measures, it is critical to determine what level of impact is being addressed. Levels of analysis could be at the Health System, Medicaid System, Health Plan and/or Provider levels. Sometimes indicators to measure change in these different levels overlap and sometimes they are mutually exclusive.

The Report on the Health Care Safety Net in Missouri by the Missouri Department of Health and Senior Services (August 2005) recommends 118 indicators for measuring health system changes with an emphasis on the changing environment for safety net providers. The indicators monitored in this study examine demand, support, structure and the environment for safety net providers. Monitoring such indicators will provide on-going analysis and early warnings when significant negative impacts are occurring. Although there are some indicators that may link to Medicaid, health plans and managed care providers, most are not specific to that level of detail. In this analysis, consideration has been given to where the 118 indicators have relevance at levels below the health system level.

For health plan and provider performance, states typically use a combination of HEDIS and CAHPS measures and measures that are developed by the state such as financial strength, call center performance, and claims payment indicators. The advantage of the HEDIS and CAHPS measures is that they are standardized, nationwide instruments, and thus can provide the state with information about how their efforts compare with others throughout the nation. There has been a great deal of discussion nationally about the applicability of HEDIS and CAHPS for the elderly and persons with disabilities because they were created for a healthier, more traditional population. As national organizations such as the National Committee for Quality Assurance wrestle with how to more appropriately measure the quality of care provided to this population,

many states are using non-standardized measures to better capture the impact of managed care specific to the elderly and persons with disabilities.

Depending on the goals established for the program, the target population, and the type of managed care initiative; the state should develop a set of indicators specific to the goals of the initiative. The process for establishing the goals and indicators, particularly for a program targeting the elderly and people with disabilities, should involve stakeholders such as advocacy groups, Medicaid beneficiaries, providers, and health plans. Planning on the front end takes time but will better prepare the state, beneficiaries and stakeholders for program implementation.

Without a clear understanding of the covered population, benefit package, service area and program goals it would not be prudent to offer recommendations on performance indicators. However, there are some examples of indicators commonly used in other states or identified in the Report on the Health Care Safety Net in Missouri that might provide a starting point for the discussion of measuring the impact of managed care expansion.

### **Access**

- Number of providers by service type per number of enrollees or capacity of providers by service type per number of enrollees
  - PCPs
  - Specialists (neurologists, orthopedists, gerontologists, psychiatrists, etc.)
  - Case managers (HMO case managers, HCBS case managers)
  - HCBS providers (personal care providers, transportation, etc.)
- Number of beds of per number of enrollees
  - Hospital inpatient
  - Hospital psych inpatient
  - Hospital – free-standing psychiatric
  - Residential treatment facilities
  - Nursing homes
  - Assisted living facilities
  - Other residential (board and care, etc.)
- Observed to expected ratio of specific events
  - Immunizations rates (pneumococcal, influenza, etc.)
  - Health check-ups
  - Screenings (mammograms, colonoscopies, osteoporosis, Alzheimer’s disease, mental/cognitive, etc.)
- Percentage of enrollees reporting unable to obtain care by specified service types

## **Quality**

- Applicable HEDIS “Effectiveness of Care” measures, such as:
  - Breast cancer screening
  - Controlling high blood pressure
  - Cholesterol management for patients with cardiovascular conditions
  - Comprehensive diabetes care
  - Follow-up After hospitalization for mental illness
  - Antidepressant medication management <sup>154</sup>

## **Satisfaction**

### PROVIDER SATISFACTION

- Overall satisfaction with Medicaid FFS
- Overall satisfaction with Medicaid managed care
- Satisfaction with Medicaid managed care programs provision of services
  - Appropriate coverage of treatment and services
  - Appropriate coverage of health promotion and disease management
- Satisfaction with Medicaid managed care programs administrative and organization aspects
  - Amount of paperwork
  - Accuracy and timeliness of claims payment
  - Level of reimbursement
  - Customer service

### MEMBER SATISFACTION

- Satisfaction with case management
- Satisfaction with nursing facilities
- CAHPS survey measures, including:
  - Composite measures
  - Getting needed care
  - Getting care quickly
  - How well doctors communicate
  - Courteousness of office staff
  - Customer service
  - Claims processing
  - Overall rating
  - Personal doctor
  - Specialist
  - Health care
  - Health plan

### **Cost/Utilization**

- Per member per month costs for specific groups (all ABD and by subgroups of dual eligibles, adults with disabilities, and children with disabilities)
  - Total
  - Inpatient
  - ER
  - Prescribed drug
  - Nursing home
  - HCBS
  
- Utilization rates of recipients by provider type, including:
  - ER
  - Inpatient hospital
  - Outpatient
  - PCP
  - Specialists
  - Nursing home
  - HCBS
  
- Penetration rates
  - HMOs
  - Other managed care arrangements

It is evident that there is no single model of managed care for the elderly and people with disabilities. However, as states pursue Medicaid managed care for this population, there are important decisions to be made prior to selecting a model and prior to selecting how to measure the impact of the model. The list below illustrates the complex decision making that must occur and for each of the possible decisions, there are a wide range of policy implications to consider.

### ***Covered Population***

The models examined include different Medicaid beneficiaries. One of the first decision to consider is whether all elderly and people with disabilities will be included in the model. For example, some states do not include persons who are dually eligible for both Medicaid and Medicare. However, other states have found that this population is an integral part of their program.

### ***Covered Benefits***

When selecting a model of care for this population, states must determine if acute and LTC services will be included in the managed care model. In addition, if LTC services are included, does that include both community and institutional care? If institutional care is included, is it for unlimited days or for a specified number of days, after which services are paid through FFS?

***Service Area***

The primary service areas for all of the models reviewed are urban areas but the number of counties or cities varies. Rural models are often more complicated but in program planning the full range of options should be weighed prior to final decision.

***Management Arrangement***

The states reviewed were managed through a wide range of options: full-risk capitated HMOs, state run non-capitated programs, contracted out non-capitated arrangements and provider capitated arrangements. These types of arrangements have an impact on potential cost-savings and provider satisfaction but may have less differentiation on the impact for quality and access.

Prior to determining these three major program considerations, the state and its stakeholders must determine the goals of the managed care program. What are the goals for access, quality, cost, and satisfaction and how do they weigh against each other? Often there are trade-offs between the goals depending on how the program is designed. The process of discussing the goals and implications for design options should be a transparent process involving all stakeholders and should be done in a timely but realistic timeframe.

## **RECOMMENDATIONS AND CONCLUSIONS**

### **Issues in the Implementation of Reform Concepts**

As states pursue the many programmatic and financing options now available to reform their Medicaid programs, it will be important to understand both the direct and indirect impact on consumers of service and safety net providers. Following are critical issues that should be monitored as any reform proposal is debated. At this juncture, in the absence of concrete proposals in Missouri, these issues are somewhat hypothetical in nature.

#### ***Program Flexibility***

- It will be important to determine whether the benefit flexibility provisions in the DRA present an opportunity for Missouri to restore any eligibility cuts made in 2005.
- In the event that Missouri decides to use DRA benefit flexibility, it will be important to enforce the DRA provision requiring that states ensure that individuals have access to FQHCs and Rural Health Clinic services and that reimbursement for services provided in these locations meets federal requirements.
- Care must be taken to guard against viewing certain benefits (e.g. dental or mental health) as non-essential, understanding that their absence can lead to increased use of services such as physician visits or hospital care.

#### ***Cost-Sharing***

- There are a variety of ways in which cost-sharing strategies may have negative impacts on the safety net. For example:
  - If increased premiums discourage enrollment of eligible people or lead to increases in disenrollment, safety net providers will not see a decrease or will see an increase in uninsured patients, particularly in hospital ERs.
  - If increased point-of-service cost-sharing discourages beneficiaries from seeking early or preventative care or causes them to forego important treatments such as filling a prescription, safety net providers are likely to see increases in patients seeking care later and with higher acuity than otherwise would have been the case.
  - It is typically hard to collect co-payments from Medicaid beneficiaries, and many safety net providers are required to deliver services even when a patient cannot or will not pay unless the state exercises its option under the DRA to allow providers to deny services.
  - Safety net providers may face a diversion of clinic resources toward finding alternative resources for patients who lose their Medicaid coverage due to higher premiums or strict enforcement of premium payment policies.
  - Safety net providers may experience an increased risk of no-show rates, patients not coming back for follow up visits and/or not having prescriptions filled because of inability to afford co-pays.

- It will be important for the state to exercise care in designing cost-sharing strategies to minimize the negative impacts on the safety net. The following should be considered:
  - What services should be exempt from cost-sharing altogether?
  - What eligibility groups should be exempt from cost-sharing?
  - What is the appropriate balance between premiums and point-of service cost-sharing?
  - What is an appropriate cap on total out-of-pocket expenditures?
  - How can the state most effectively educate beneficiaries so that they understand the cost-sharing policies and seek appropriate care?

### **Healthy Behavior Incentives**

- Effective incentives to reward desired behaviors, particularly those that promote disease management and wellness strategies, can have a positive effect on the safety net by decreasing inappropriate use of emergency facilities and potentially involving safety net providers as partners in disease management initiatives.
- There are potential unintended consequences of healthy behavior incentives. To be effective, incentives need to be powerful enough to change behavior. At the same time, unintended consequence can result when basic health care services are conditioned upon certain behaviors. For example:
  - To the extent that beneficiaries are unwilling or unable to comply with their agreements and therefore lose some of their Medicaid benefits, providers could see increased ER utilization or increased acuity of conditions for inpatient admissions, particularly where there is a lack of follow up care or insufficient management of chronic health conditions that could have serious health consequences.
  - To the extent that beneficiaries are unwilling or unable to comply with their agreements and therefore lose some of their Medicaid benefits, providers could see increased reliance on safety net providers as a source of care for services that would no longer be reimbursed by Medicaid.
  - If medical practitioners are required to monitor and report patient compliance with the healthy behavior agreement, providers face an increased administrative burden for Medicaid patients. This responsibility could also lead to practitioners playing the conflicting roles of both patient advocate and enforcer.
  - To the extent that provider participation in Medicaid already is tenuous, the administrative burden associated with monitoring and reporting patient compliance may lead some providers to leave the program. They may also shift any unreimbursed costs associated with the activity to private pay patients.

### **LTC Partnership Programs**

- While developing LTC insurance strategies may be important, the impact of these initiatives will be felt gradually, since LTC insurance is typically purchased several years in advance of needing the benefit. LTC insurance is not an option for the elderly and people with disabilities who are currently in need of or at-risk for institutionalization. Any speculation about the impact of this strategy should be viewed with caution.

### **Federal Caps and Restrictions on Safety Net Funding**

- It is likely that CMS will require limits on Missouri's current Medicaid financing strategies and payment methodologies, e.g. DSH payments and UPL funding in exchange for federal approval of the state's Medicaid reform plan.

### **Medicaid Managed Care and Revenue Preservation Strategies**

- Implementation or expansion of capitated Medicaid managed care will impact revenue preservation strategies such as UPL unless the two can be preserved as part of a Medicaid reform waiver. It will be important to consider these impacts when looking at the overall cost picture. Some states have been successful in proposing new uses for funds that had been available to support the safety net.
- Expanding managed care, either to new geographic areas or new populations, may present challenges for safety net providers. Safety net providers need to be poised to contract with MCOs so that they can become part of managed care provider networks.
- Care must be taken that any expansion of managed care to the elderly or people with disabilities is accompanied by enforceable requirements that participating MCOs have the necessary expertise and knowledge to competently serve them.
- It will be important to ensure that managed care is designed and implemented in a way that emphasizes prevention and acts as a vehicle for developing improved strategies for treating and managing chronic diseases and for improving access to specialty providers such as mental health practitioners.

## **Plain Talk About Launching Medicaid Reform Initiatives**

As the state considers Medicaid reform initiatives, whether focused on encouraging healthy behavior, or implementing managed care expansion to the ABD population, following are some general guidelines that will help to ensure the success of Missouri's efforts.

- Once the state has committed to broad directions in reforming the Medicaid program, the details of implementation will be the order of the day. This will be the time to bring all of the affected parties to the table in a public process.
- Just because the legislative debate has concluded and the state is embarking on a public process to implement the state's Medicaid reform decisions, stakeholders should not be expected to set aside their concerns. In fact, all stakeholders should be encouraged to bring those concerns to the task of implementing Medicaid reform in a way that averts harm and improves the health status of Missouri's Medicaid enrollees.
- Go into Medicaid reform implementation knowing it is going to be complicated work that carries the potential of serious risks to the well-being of individuals and of the critical safety net system in the state. Building something completely new is a daunting task, but it is vastly less challenging and complicated than changing an existing system on which almost a million Missourians count for their health care. With that in mind, be judicious in setting expectations as to how long it will take to put the reform initiatives in place. Establish realistic timelines.

Take the time to get it right the first time. It is a whole lot easier than going back and cleaning up mistakes, especially where mistakes can have very real human costs.

- Building a realistic timeline is critical but so are resources. Recognize going in that the same people probably are not going to be able to do the work of changing the system while they continue to run the existing system day-to-day. Plan to dedicate the necessary staff resources (whether internal or a combination of internal and contracted) to get the job done. This means assembling a group of people who will have no other responsibilities but planning and implementing the reform initiatives. The numbers and expertise of staff necessary will depend on the final outlines of Missouri's reform plan.
- The time to make provision for evaluating the outcomes of the reform initiatives is not 6 or 12 or 24 months into Missouri's new Medicaid world. The evaluation should be designed at the same time that the implementation details are being worked out. An evaluation plan and the resources to carry it out should be established by the day that the reform initiatives "go live."
- States cannot know where they are unless they know from whence they came. That is another way of saying that it is important to establish a baseline that paints a picture of Medicaid as it is today, before reform. Select the measurable indicators that will tell the state in the months and years after the reform process begins what is working about the reform initiatives and what is not. If Missouri's Medicaid program does not measure those indicators today, a reading must be taken now in order to document the state's starting point.
- Many of the Medicaid reform concepts being pursued around the country increase states' reliance on outside vendors. As part of implementation, assess the state's capacity to manage contracts with those vendors. Measure that capacity not only in terms of the number of staff with contract management in their job descriptions, but in terms of whether those staff have the right expertise and business processes that support contract oversight. These are some of the hidden costs of change and they are often the ones states neglect to take into account in a timely fashion, often to their later regret.

## Appendix A - State Medicaid Reform and Coverage Expansions

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Arizona	KidsCare expansion	To be determined	Uninsured children whose family income is under \$60,000 per year	<p>A formal proposal has not yet been developed; however, Governor Napolitano has expressed her intention to:</p> <ul style="list-style-type: none"> <li>-Provide every child under age 19 whose family makes less than \$60,000 with access to affordable health care through the Arizona Health Care Cost Containment System (AHCCCS) KidsCare program.</li> <li>-Repeal “gag rule” that prohibits teachers and schools from talking to parents about obtaining health coverage for their children.</li> </ul>	Announced in Governor’s State of the State Address.
California	Governor’s Health Reform Proposal	Section 1115 Waiver	Uninsured Californians	<ul style="list-style-type: none"> <li>-Employer mandate requires employers w/ 10 or more employees to offer coverage in amount equal to 4% of payroll.</li> <li>-Individual mandate.</li> <li>-Uninsured children up to 300% of FPL eligible for state-subsidized coverage (regardless of residency status).</li> <li>-Uninsured adults who are legal residents with incomes below 100% of FPL eligible for Medi-Cal at no cost.</li> <li>-Uninsured adults who are legal residents with incomes between 100-250% of FPL would have access to coverage through a state purchasing pool operated by Managed Risk Medical Insurance Board. Individuals share in the cost of premium based on percentage of income.</li> <li>-Health Actions incentives and rewards program.</li> </ul>	Proposal released in January 2007; not yet introduced as legislation.
	Medi-Cal Hospital/ Uninsured Care and Medi-Cal Redesign	Section 1115 Waiver	Medicaid children and families and seniors and people with disabilities	<ul style="list-style-type: none"> <li>-Managed care expansion with mandatory enrollment for certain groups.</li> <li>-Restructuring of hospital financing.</li> <li>-Refinancing of the safety net to expand coverage for the uninsured.</li> </ul>	Approved by CMS in June 2005. Additional federal funding was contingent upon meeting certain milestones. The state missed a milestone for enactment of legislation regarding managed care expansion.
Connecticut	The Charter Oak Health Plan/ HUSKY Health 2007	To be determined	Uninsured Huskies	<ul style="list-style-type: none"> <li>-Creation of a health insurance plan, called the Charter Oak Health Plan, with monthly premiums of no more than \$250 to expand coverage to the uninsured.</li> <li>-The state would help connect uninsured adults with insurers participating in the Charter Oak Health Plan, in part through a 211-Infoline service. There would be no cost to the state for the Charter Oak Health Plan, other than nominal administrative and marketing support.</li> <li>-The plan would discourage costly ER visits by requiring clients to bear a portion of the costs for ER visits for non-emergency situations.</li> <li>-HUSKY Health 2007 initiative will help ensure that every uninsured newborn and school-age child is enrolled in the state’s HUSKY Plan.</li> </ul>	Will be discussed in the 2007 legislative session.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Florida	Medicaid Modernization	Section 1115 Waiver	Medicaid children and families and seniors and people with disabilities  Other voluntary Medicaid populations	-Transforms Medicaid from a defined benefits program to a defined contribution program, with state becoming a purchaser of health care. -Health plans determine amount duration and scope of services. -Enrollees provided risk-adjusted premiums to select a sponsored Medicaid plan. Enrollees may “opt out” of Medicaid and use premium to purchase ESI. -Enhanced Benefit Accounts reward healthy behaviors. Enrollees can use funds to purchase additional services. -Low-income pool for safety net providers.	Approved by CMS in October 2005. Pilot launched in Duval and Broward Counties in 2006. Pilot will expand to three additional counties in July 2007. Statewide implementation subject to legislative approval and not anticipated before July 2008.
Georgia	Healthy Families	Section 1115 Waiver	Medicaid children and families	-Mandatory Medicaid managed care expansion with flexible benefit packages for mandatory and optional populations. -Co-payments and sliding scale premiums. -Consumers can choose to participate in Health Spending Accounts which encourage healthy choices. Accounts can be used for individual and family coverage. Excess funds can be used to pay cost-sharing or to purchase optional benefits.	A concept paper was submitted to CMS in May 2005. In 2006, the state indicated that it would delay reforms until 2007 and possibly scale back the scope. Managed care expansion began in Atlanta and the central area in June 2006. The remaining regions were rolled out in September 2006.
Idaho	Medicaid Modernization	SPAs under the DRA	All Medicaid enrollees	-Medicaid eligibility is collapsed into three groups based on need; benefits packages are modified for each population. <ul style="list-style-type: none"> <li>• Benchmark Basic Plan: For healthy children and adults. Traditional Medicaid services with some exceptions. All enrollees receive services through a PCCM program. “Preventive health assistance” for tobacco cessation and obesity is available, as well as additional benefits for individuals that complete activities addressing the targeted condition.</li> <li>• Enhanced Plan: For people needing services not covered in the Basic Plan. Traditional Medicaid benefits including LTC. All enrollees receive services through a PCCM program.</li> <li>• Coordinated Benchmark Plan: For dual-eligibles. An integrated Medicare-Medicaid plan to be provided by Medicare Advantage plans.</li> </ul> -All Plans have voluntary enrollment with an “opt-out” to Standard Medicaid. State has applied for an SPA to eliminate optional benefits from Standard Medicaid including pharmacy, certain prevention and wellness benefits, and other services, which is pending CMS approval. Enrollees may also opt-out to ESI. -Personal Health Accounts to encourage healthy behaviors. -Consumer-directed support services for special needs and disabled (i.e., cash & counseling). - P4P pilot for chronic diseases.	Many parts of Idaho’s reform proposal have been approved by CMS. State is still waiting for other approvals, including: An SPA to implement a chronic disease management pilot based on pay-for-performance; a self-directed service option under the developmental disabilities waiver; and moving the Healthy Connections waiver into Benchmark Plan. Statewide implementation of the Basic and Enhanced plans began in July 2006. Implementation of the Coordinated Benchmark Plan for dual-eligibles is expected in April 2007.
Illinois	Health Care Justice Act	To be determined	Uninsured children and adults	-Public programs will also be expanded to cover additional low-income parents, childless adults with very low incomes, and specific disabled populations. State-funded premium subsidies will be available for residents below 400% of FPL. -A comprehensive, standard benefit package (“Comprehensive Standard Plan”) will be available on a guaranteed-issue basis to all individuals and small groups through a state self-insured plan or mandate in the private market. -All Illinois residents, including undocumented immigrants and non-resident college students, must obtain qualified health insurance coverage or pay a penalty. -Employers will be expected to contribute to health insurance coverage for their workers by paying a per worker assessment (approximately \$1,000 per employee) that will be used to partially cover the cost of the premium subsidies.	Proposal will go before the legislature in early 2007.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Indiana	Governor's Plan for Healthier Indiana	Section 1115 Waiver	Uninsured parents up to 200% of FPL  Childless adults between 100% FPL to 200% FPL (leaving the poorest still uninsured)	<p>-Modeled after HSA concept, combining access to funds in an individual account with high deductible insurance product. Insurance coverage is limited to \$300,000 per year and \$1 million lifetime.</p> <p>- Personal Wellness Responsibility (POWER) Accounts will be available with \$1,100 to pay for medical costs. When medical costs exceed \$1,100, a basic commercial benefits package is available.</p> <p>- The POWER account is funded through contributions by the state and each participant based on ability to pay. No participant shall pay greater than 5% of gross family income on the plan.</p> <p>-If participants meet certain preventive care requirements, they may withdraw or roll over fund balances in excess of \$500.</p> <p>-50 cent cigarette tax would generate \$207 million.</p>	Conceptually introduced by the governor in November 2006. Bill expected to be introduced in January 2007.
Kentucky	KyHealth Choices	SPA under the DRA	Most Medicaid enrollees	<p>-Establishes four defined benefit packages which vary for specific populations:</p> <ul style="list-style-type: none"> <li>• Global Choices: Standard Medicaid with increased cost-sharing for adults, pregnant women, foster children, non-LTC aged and disabled.</li> <li>• Family Choices: For most Medicaid and SCHIP children. The benchmark benefit package provided is similar to Global Choices but with emphasis on preventive services. May be expanded to include uninsured parents in the future.</li> <li>• Optimum Choices: Aged and disabled needing ICF/MR level of care. Members may "opt out" to Global Choices benefits.</li> <li>• Comprehensive Choices: Aged and disabled meeting nursing facility level of care needs. Members may "opt out" for Global Choices benefits.</li> </ul> <p>-Enrollees have option of receiving a subsidy to purchase ESI instead.</p> <p>-Means-tested co-payments and premiums for services other than preventive care.</p> <p>-Get Healthy Accounts established for specific targeted diseases. Can earn funds and other benefits for participating in disease management. Funds can be used to offset cost-sharing and non-covered health services.</p> <p>-Consumer-directed Options will provide a consumer-directed option delivery model for LTC, with Support Brokers (Area Agencies on Aging) providing assistance in developing a care plan, a financial plan and oversight to the hiring of caregivers.</p> <p>-State submitted SPA for DRA HCBS.</p>	SPA approved in May 2006. Still negotiating with CMS over Optimum Choices benefit. Kentucky wants to use a Section 1115 waiver; CMS is pressuring for use of 1915(c) waiver or SPA. State submitted SPA December 15, 2006 for HCBS under the DRA. Implementation of new benefit packages and cost-sharing began in 2006.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Louisiana	The Louisiana Health Care Redesign Collaborative	Section 1115 Waiver		<ul style="list-style-type: none"> <li>-Creates a medical home system of care for the New Orleans region. The medical home will be available to all residents of the region including the uninsured, Medicaid, and Medicare recipients and those who now have insurance coverage.</li> <li>-Health insurance coverage (phased-in) through the “Health Insurance Connector.” The connector, as well as premium subsidies for low-income residents, will ensure that all citizens have affordable insurance options.</li> <li>-Allows families of uninsured children from 200% to 300% of FPL to buy in to Medicaid for their children.</li> <li>-Expands coverage to pregnant women with incomes up to 200% of FPL.</li> <li>-Gives existing Medicaid and SCHIP enrollees a choice of coverage models including private insurance.</li> <li>-Covers uninsured parents with incomes up to 200% of FPL and uninsured childless adults with incomes up to 200% of FPL.</li> <li>-Provides coverage to individuals with serious mental illness and addictive disorders.</li> <li>-The HIT initiative includes electronic medical and health records that would link all providers in a medical home network.</li> </ul>	A concept paper was submitted to the federal government in October 2006. State officials are discussing which recommendations by the Louisiana Health Care Redesign Collaborative can be implemented without a federal waiver. State and federal officials are working to reach an agreement on a "common set of assumptions" of the cost of expanding health care coverage to the uninsured. Many of the extensive policy goals outlined by the collaborative may not be enacted anytime soon.
Massachusetts	Massachusetts Health Care Reform Plan	Section 1115 Waiver	Uninsured children and adults	<ul style="list-style-type: none"> <li>-Creates a mandate that all individuals over the age of 18 have health insurance coverage or face tax penalties.</li> <li>-Requires employers with over 11 employees to contribute a “fair share” to their employees’ health insurance or pay up to \$295 annually per employee.</li> <li>-Creates the Commonwealth Health Insurance Connector to “connect” individuals to insurance. Small businesses and individuals can purchase insurance through the Connector.</li> <li>-Employers with more than 10 workers will be required to offer a Section 125 “cafeteria plan” that permits workers to purchase health care with pre-tax dollars. Using these pre-tax dollars, workers not offered insurance will be able to purchase insurance products through the Connector.</li> <li>-Provides government-funded subsidies to low-income individuals to assist with the purchase of health insurance, based on a sliding scale to individuals with incomes up to 300 % of FPL. Individuals with incomes less than 100% of FPL will not be required to pay any premiums. Plans will be offered by MCOs that participate in the Medicaid program.</li> <li>-Expand Medicaid to children up to 300% of FPL. Enrollment caps on existing Medicaid programs for adults raised.</li> </ul>	<p>HB 4850 was signed into law in April 2006.</p> <p>Full implementation of the plan is expected by July 1, 2007.</p>
Minnesota	Healthy Connections	To be determined	Uninsured children and adults	<p>Governor Pawlenty introduced a reform plan that includes the following components:</p> <ul style="list-style-type: none"> <li>-Offer a more affordable private sector alternative to MinnesotaCare, called “Minnesota Care II”, that focuses on rewarding healthy outcomes and includes bonus accounts. All health plans with more than 3% market share in the individual market will be required to offer the plan to kids and will have the option of offering the plan to adults.</li> <li>-Increase affordable access to health care coverage for kids by reducing current premiums and expanding coverage options.</li> <li>-Establish the Minnesota Health Insurance Exchange to connect employers, employees, MinnesotaCare recipients, and individuals to more affordable coverage options.</li> <li>-Provide small employers and their employees with more affordable coverage.</li> <li>-Lower out-of-pocket costs for individuals purchasing insurance through the private market.</li> </ul>	HealthyConnections will be discussed in the 2007 legislative session.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Missouri	Health Care Home – FQHC Initiative	To be determined	Medicaid enrollees	-Plan to improve health care quality and access for Missourians by implementing a health care home model for those insured by Medicaid. FQHCs would be a centerpiece of this proposal. -Recommends an additional \$5 million next year for an HIT Initiative.	Announced by the governor in January 2007. The plan will be discussed and detailed in the upcoming legislative session.
Montana	A Proposal to Provide Health Care Services to Uninsured Low-Income Montanans	Section 1115 Waiver	Uninsured children, parents and adults	-Expands coverage to approximately 5,000 individuals including: <ul style="list-style-type: none"> <li>• 1,600 children on SCHIP waiting list and 300 children 18-20 with Serious Emotional Disturbance (SED).</li> <li>• 600 working parents with Medicaid eligible children who are losing transitional Medicaid benefits.</li> <li>• 1,200 Uninsured parents and youth below 200% of FPL.</li> <li>• 1,500 uninsured adults with mental illness.</li> <li>• Up to 260 uninsurable high risk pool adults.</li> </ul> -Leverages savings from existing 1115 waiver to increase coverage. -Leverages federal match for state funded programs to expand coverage. -Allows benefit and enrollment limits for newly covered populations. No new cost-sharing.	Waiver application submitted in July 2006.
Nebraska	Medicaid Reform	SPA and HCBS Waiver	Medicaid enrollees	-A proposal introduced by the state in 2005 recommended that reforms: <ul style="list-style-type: none"> <li>• Avoid both expansions and restrictions to benefits, eligibility, and provider reimbursements.</li> <li>• Focus on strengthening administrative improvements and oversight.</li> <li>• Explore alternative funding mechanisms to offset increases in general fund expenditures.</li> <li>• Focus on high cost areas and populations: LTC, inpatient hospital, and prescribed drugs.</li> <li>• Encourage personal choice and responsibility.</li> <li>• Increase access to FQHCs and health centers.</li> </ul> -Also recommends establishing a separate SCHIP program for children in families between 150% and 185% of FPL to allow additional cost-sharing. Waiver recipients with family incomes above 150% FPL would also be subject to cost-sharing.	Many recommendations have yet to be formalized. An SPA was filed to obtain approval of a LTC Partnership Program which would allow individuals with qualified insurance policies that cover LTC to protect an equivalent amount of assets for Medicaid eligibility and estate recovery purposes. A consumer-directed HCBS delivery model (i.e., cash and counseling) became effective in August 2006.
New Jersey	Universal coverage	To be determined	Uninsured residents of New Jersey	-Insurance mandate. -State subsidized HMO or PPO for people that do not have employer-based coverage. -Sliding premium scale. -Businesses not required to offer coverage.	A proposal should be introduced in the legislature Spring 2007.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Ohio	Ohio Health Care Exchange	Section 1115 Waiver	Uninsured adults up to 150% of FPL	<ul style="list-style-type: none"> <li>-The state will partner with insurance companies and small business to make private health plans available to all Ohioans through a free-market exchange that takes advantage of the power of group purchasing.</li> <li>-Premium support will be available for adults up to 150% of FPL.</li> <li>-Create the Ohio Health Care Exchange.</li> </ul>	Will be announced in the governor's State of the State address in February 2007.
Oklahoma	Oklahoma Medicaid Reform Act of 2006	Section 1115 Waiver	Medicaid enrollees  Over age 65 enrollees excluded	<p>The Oklahoma Medicaid Reform Act requires the state to apply for a federal waiver to enact the following:</p> <ul style="list-style-type: none"> <li>-Transform the program into a defined contribution rather than a defined benefit program.</li> <li>-Allow private insurers to offer plans to enrollees. Enrollees would be issued a voucher to purchase commercial insurance. Voucher amount would be based on the average cost of medically necessary services for a specific category of service. There will be a counseling component to help enrollees understand available plan choices.</li> <li>-Create PHA or an "enhanced benefits" system to allow beneficiaries to use money in their PHA to defray certain health care costs.</li> </ul>	HB 2842 signed into legislation in June 2006. Phase I is to be implemented by July 1, 2008 within a contiguous area of the state with rural and urban characteristics. Upon evaluation, if the program is effective, it will be expanded statewide by 2013.
Oregon	Healthy Kids	Section 1115 Waiver	Children and uninsured low-income adults	<ul style="list-style-type: none"> <li>-Increase state cigarette tax to help cover all kids and expand Medicaid for adults.</li> <li>-Premiums to be based on a sliding scale. Families below 200% of FPL would not have to pay a premium.</li> <li>-Benefits will be based on the OHP.</li> </ul>	A proposal should be introduced in the legislature in 2007. Implementation planned January 2008. The program will be competitively bid.
Pennsylvania	Cover All Residents of Pennsylvania		Uninsured adults  *Note: Universal coverage for all children was previously obtained under the governor's <i>Cover All Kids</i> initiative	<ul style="list-style-type: none"> <li>-The plan will make affordable, basic health insurance coverage available to small businesses and the uninsured through the private insurance market.</li> <li>-Eligible businesses that choose to join will pay approximately \$130 per employee per month and employees will pay premiums on a sliding scale (up to \$70).</li> <li>-Uninsured adults below 300% of FPL will be provided discounts and subsidies to access the coverage. Uninsured adults above 300% of FPL can purchase coverage for the full premium, approximately \$280 per month.</li> <li>-Fair share assessment on all businesses that do not insure their employees.</li> <li>-Consumer incentives will reward healthy lifestyles.</li> </ul>	Governor Rendell will announce his budget proposal in early February, which will contain more details about the financial aspects of the plan. Will require both legislative and federal approval. If necessary approvals are received in a timely fashion, the program will begin operations in January 2008. An insurance mandate for persons above 300% of FPL and all full-time college and graduate students will be phased in.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
South Carolina	South Carolina Healthy Connections	SPA under the DRA  Health Opportunity Accounts Demonstration	Most Medicaid enrollees	<p>-PHAs are provided to enrollees in an amount based on current FFS spending and are risk-adjusted. Enrollees are given four options for using their account funds: Private insurance, a medical homes network, ESI, or the self-directed care opt-out. Account balances will be maintained in a Stored Value Card which can be used to purchase additional medical services, co-pays, or to purchase insurance after losing Medicaid eligibility.</p> <p>-Under the self-directed care opt-out option, a portion of the PHA would be used to cover major medical expenses and preventative care. The remaining balance can be used to purchase care directly from providers. Only certain enrollees are eligible for this option.</p> <p>-Significant increases in some co-payments for adults.</p>	Originally submitted an 1115 waiver but is now negotiating with CMS to approve some or all aspects of the proposal as an SPA under the DRA instead. Enrollees will be phased into Healthy Connections. The state started offering enrollment choices to individuals in Marion and Orangeburg County in 2006. The options included managed care plans with expanded benefits and care coordination.
Tennessee	Cover Tennessee	SPA and possible Section 1115 waiver	Uninsured children and adults	<p>-Three programs created to help insure those who lost coverage under TennCare and help small businesses offer coverage.</p> <ul style="list-style-type: none"> <li>• <i>CoverTN</i>: The state, employers and employees will each contribute 1/3 to cover premiums to help expand health coverage to low-income, uninsured working adults.</li> <li>• <i>Access TN</i>: High risk health insurance pool—plans with monthly premiums between \$273 and \$1,156 and with varying deductibles are offered to individuals with one of 54 specified medical conditions or proof that they have been rejected from at least two insurance companies because of existing health conditions. The state will cover between 25% and 75% of the costs for beneficiaries who have annual incomes up to 250% of FPL.</li> <li>• <i>CoverKids</i>: SCHIP expansion to cover kids under 250% of FPL. Kids in families with incomes above 250% of FPL can buy in. No deductibles or premiums.</li> </ul> <p>-Other programs were also created including, <i>CoverRx</i> (expands safety net program for affordable medication) and <i>Project Diabetes/Coordinated School Health</i> (expands pilot teaching health lifestyles in schools and launches a grant program to reduce Type 2 Diabetes and obesity).</p>	<i>Cover Tennessee</i> program was signed into legislation in June 2006. In conversations with CMS regarding application for a Section 1115 HIFA waiver for AccessTN. BlueCross BlueShield of Tennessee awarded <i>CoverTN</i> contract. Enrollment in <i>AccessTN</i> will begin in February 2007. <i>CoverKids</i> implementation to begin in March 2007.
Virginia	Medicaid Reform	To be determined	To be determined	<p>A formal proposal has not yet been developed. However, a “Medicaid Revitalization Committee” was created by statute in 2006 and recently issued the following recommendations (among others) for Medicaid reform:</p> <ul style="list-style-type: none"> <li>• Disease management expansion.</li> <li>• Enhanced benefit accounts where beneficiaries are rewarded for healthy behaviors.</li> <li>• Managed care expansion.</li> <li>• Study the feasibility of ESI or private insurance for beneficiaries.</li> <li>• Expand “buy in” programs.</li> </ul>	The Department of Medical Assistance Services (DMAS) must review the recommendations and submit any necessary SPA or waiver to CMS for approval by May 15, 2007.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
Vermont	Global Commitment to Health	Section 1115 Waiver	Most Medicaid enrollees  SCHIP and LTC excluded	<ul style="list-style-type: none"> <li>-Global cap-block grant type structure established on expenditures for covered population.</li> <li>-State agency functions as a public MCO for financing purposes and receives a "premium" for each enrollee.</li> <li>-Flexible financial mechanism allows state to use savings to finance a wide range of health services for un- or underinsured including premium subsidies for ESI.</li> <li>-Cost-sharing limited to 5% of family income.</li> </ul>	Approved by CMS in September 2005. FY06 budget bill approved the creation of the Office of Vermont Health Access (OVHA) as a public MCO. Statewide implementation began in October 2005.
	Catamount Health	Federal funding provided under the Global Commitment to Health Section 1115 Waiver	Uninsured Vermonters without access to ESI	<ul style="list-style-type: none"> <li>-Creates Catamount Health, a state-funded insurance program for the uninsured, and requires employers to pay assessments if they do not offer health care coverage.</li> <li>-Catamount Health provides coverage for primary and preventive care and for a disease management initiative.</li> <li>-The State subsidizes premiums on a sliding scale based on participants' incomes.</li> <li>-Funding for Catamount Health comes from the federal government, employer assessments, a 60-cent-per-pack increase in the state's cigarette tax, and payments that tobacco manufacturers will make to the state beginning in 2008.</li> </ul>	The governor signed legislation in May 2006 creating the Catamount Health program. Pre-implementation action began in July 2006. Private insurance companies will begin selling Catamount policies beginning in October 2007.
Washington	The Blue Ribbon Commission on Health Care Costs and Access	To be determined	Uninsured adults and children	<p>The Blue Ribbon Commission on Health Care Costs and Access was created by statute to deliver a five-year plan for substantially improving access to affordable health care for all Washingtonians. Its recommendations include ensuring access to effective care to all residents by 2012. Lawmakers already have pledged to make sure all children have health insurance by 2010. Other recommendations include:</p> <ul style="list-style-type: none"> <li>-Using state purchasing to improve health care quality by rewarding good outcomes and practices with the state's clout as a major purchaser.</li> <li>-Better management of patients with chronic illnesses.</li> <li>-Better use of HIT to manage records and share information electronically.</li> <li>-Reducing costly ER visits by people who can get care more cheaply and effectively in clinics.</li> <li>-Giving people more choice in selecting private insurance plans and requiring insurers to cover dependents of insured families up to age 25.</li> <li>-Improving coverage through partnership with the federal government to reduce the number of uninsured (593,000 people, of whom 390,000 are in low-income households) in Washington.</li> <li>-Reorganizing insurance market so it is more accessible, using possible state subsidies and pools of insured to win better rates.</li> </ul>	In January 2007, the governor released the final version of the Blue Ribbon Commission's report. Washington lawmakers already have pledged to make sure all children have health insurance by 2010.

State	Initiative	Federal Authority	Population Affected	Key Elements of Reform or Expansion Proposal	Status/Implementation
West Virginia	West Virginia Comprehensive Medicaid Redesign Proposal	SPA under the DRA	Healthy adults and children	<p>-SPA provides for a Basic Plan and an Enhanced Plan. The Basic Plan provides all state and federal mandatory services. The Enhanced Plan provides additional services. Enrollees must sign a Personal Responsibility Contract in order to enroll in the Enhanced Plan. Compliance with four responsibilities will be monitored:</p> <ul style="list-style-type: none"> <li>• Screenings as directed by health care provider.</li> <li>• Adherence to health improvement programs.</li> <li>• Missed appointments.</li> <li>• Medication compliance.</li> </ul> <p>-Failure to comply with responsibilities will result in moving back into the Basic Plan. The Basic Plan excludes many services, including diabetes care and chemical dependency/mental health services.</p>	SPA approved in May 2006. Pilot will be launched in three rural counties in early 2007. Expansion statewide by early 2008.
Wisconsin	Healthy Wisconsin	To be determined	To be determined	<p>The Healthy Wisconsin Council was appointed in Summer 2006 by Governor Doyle to recommend ways to cut the number of uninsured in half. The council recommended a \$1 per-pack cigarette tax increase to help expand Medicaid eligibility. Other council recommendations included:</p> <ul style="list-style-type: none"> <li>• Creation of a reinsurance pool for catastrophic care claims to make health care more affordable for small businesses</li> <li>• Medicaid payment rate increases.</li> </ul>	The governor has indicated that he will take the council's recommendations into consideration as he drafts the 2007-08 budget.

## Appendix B – Code of Federal Regulations

### Code of Federal Regulations

#### Section 438 Managed Care, 438.206 Availability of Services

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:

- (i) The anticipated Medicaid enrollment.
- (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.
- (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
- (iv) The numbers of network providers who are not accepting new Medicaid patients.
- (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

(2) Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

(3) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them.

(5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(6) Demonstrates that its providers are credentialed as required by Sec. 438.214.

(c) Furnishing of services. The State must ensure that each MCO, PIHP, and PAHP contract complies with the requirements of this paragraph.

(1) Timely access. Each MCO, PIHP, and PAHP must do the following:

- (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
- (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
- (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
- (iv) Establish mechanisms to ensure compliance by providers.
- (v) Monitor providers regularly to determine compliance.
- (vi) Take corrective action if there is a failure to comply.

(2) Cultural considerations. Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

## **Appendix C - Stakeholder Perspectives on Medicaid Reform: Interview List**

**Kirsten Dunham**

Associate Policy Director  
Paraquad

**Michelle Ducre**

Executive Director  
Community Health Clinic of Joplin

**Robert Freund, Jr.**

Chief Executive Officer  
St. Louis Regional Health Commission

**Gerard Grimaldi**

Director of Business Strategy and  
Governmental Relations,  
Truman Medical Centers

**Kathleen Haycraft, AFPN**

Family Nurse Practitioner  
Pike Medical Clinic

**Al Johnson**

Chief Financial Officer  
Truman Medical Centers

**Daniel Landon**

Vice President of Government Relations  
Missouri Hospital Association

**Joe Pierle**

Executive Director  
Missouri Primary Care Association

**Katie Plax**

Director  
St. Louis Children's Adolescent Center  
University of Washington  
Medical School

**Charles Van Way, MD**

Chair, Task Force on Medicaid Reform  
Missouri State Medical Association  
Chief of Surgery  
Truman Medical Centers

**Sherri Wood**

Executive Director  
Kansas City Free Clinic

## **Appendix D - Executive Summary: 2007 Medicaid Transformation Grants**

On January 25, 2007 CMS awarded 33 Medicaid Transformation Grants totaling \$103 million to 27 states pursuant to the DRA. Section 6081 of the DRA authorizes new grant funds to states for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid.

CMS has indicated that it is open to using Medicaid Information Technology Architecture (MITA) funding to support parallel projects in those states that were not awarded Transformation Grants. The grants awarded fell into nine general categories. The following project-specific summaries are organized into those same categories.

### ***Credentialing of Providers***

#### **MICHIGAN**

The One Source credentialing process would be built on the combined requirements of Michigan's Medicaid Provider Enrollment Unit and the state's licensing process. In addition, the state's process will be updated to use existing primary source verification. The process will collect information on proof of subspecialty, proof of license, and certification or registration for providing certain Medicaid specialized services. A provider will no longer need to submit a hard copy of their in-state or out-of-state license because this information will be available electronically following primary source validation guidelines. Adverse actions will be communicated through One Source to the Medicaid payment systems, licensing, and to the National Practitioner Databank. Actions taken and reported by others to licensing agencies or the Databank would be available to One Source. Other payers or providers that participated in One Source system would have real time access to this information.

The typical credentialing process requires the provider to submit any or all of the following to state government, payers, health care groups, and facilities: educational transcripts, years of experience and experience details, board certifications, professional reference, and specialties.

### ***Electronic Verification of Citizenship***

#### **ARKANSAS**

The Electronic Verification of Proof of Citizenship project will create a computer database and software to allow multiple users to confirm the existence of an Arkansas birth certificate. Users in Medicaid offices will be able to obtain verification of fact of birth in other states participating in the Electronic Verification of Vital Events (EVVE) system. The system is active in six states – MO, IA, MN, SD, ND, and MT. Quality improvements to correct flaws in the birth index back to 1935 will be addressed. A complete index of deaths to all born since 1935 will be created allowing the birth record of a deceased person to be flagged. The AR data files will be accessed only by the central EVVE server, which will broker verification requests coming from the 57 jurisdictions to protect AR computers from unauthorized intrusions and viruses.

#### **Massachusetts**

The project for Secure Verification of Citizenship through Automation of Vital Records will provide timely verification of Medicaid citizenship eligibility at point of application, reducing delays in approval by obtaining verifications directly from the source and allowing for rapid identification of deceased persons. All of which will allow Medicaid agencies to quickly cease

benefits when necessary. Massachusetts vital records will be digitized. Records and data entry from 1935 to present which are currently paper-based will be optically scanned and entered into a database via optical character recognition (OCR) for the creation of an electronic database. Existing technology developed by the National Association of Public Health Statistics and Information Systems (NAPHSIS) for instant verification of birth and death events (which is active in MO, IA, MN, SD, ND, and MT) will be utilized and will ultimately allow for nationwide verification of vital records.

## **MICHIGAN**

The project will improve Department of Human Services (DHS) citizenship validation capability through revising the DHS Medicaid eligibility intake worker interface to the Birth Registry System (BRS), improve the reliability of Medicaid BRS search results through identifying and resolving missing BRS birth data, link death records to birth records to provide Medicaid intake and quality improvement staff a source of death information to identify applications using false identity, and upgrade interface screens to increase the ability of Medicaid staff to properly locate and confirm birth facts in BRS. Web based reporting of newborns and automation of death reporting will be part of the project.

## **RHODE ISLAND**

The IT Infrastructure Transformation effort will implement the National Association of Public Health Statistics and Information Systems (NAPHSIS) vital statistics database to meet the citizenship verification requirements of the DRA and update and replace the current MMIS Surveillance Utilization and Review Subsystem (SURS). The project also will take advantage of the new generation of decision support tools, such as EDS' DSSProfiler, proposed here, to maximize recoveries from SURS activities and position the RI to be compliant with the forthcoming Medicaid Integrity Program (MIP).

## ***Electronic Health Information Exchange/System/EHR Hub***

### **ALABAMA**

This project would create a statewide, central, shared interoperable electronic health information system (HIS) that links Medicaid, state health agencies, providers, and private payers. Components of the project include: a Stakeholder Council (develop policies that address governance, technology, process, data management, privacy, security, and other legal matters); interoperable patient data hub (PDH) (providing secure real time access to individual health information, claims, immunization records, prescription data, and laboratory results); pilot of utilization of PDH by the AL Medicaid agency and one other HHS agency; claims based EHRs (medical claims data will augment records through data matches with other third party insurers when appropriate); a process, in partnership with FQHCs, RHCs, and hospital ERs to create health records for uninsured individuals; and development of a common identifier for Medicaid beneficiaries. Prescribers will e-prescribe directly to the dispensing pharmacy and the state will pursue inclusion of diagnosis on e-prescriptions. Initial health records will include hospital, medical, and pharmacy claims data, and laboratory values reported from AL commercial laboratories. In addition, a comprehensive, data-driven, outcome-focused quality improvement (QI) model for AL Medicaid will be established with at least two Medicaid nurses reassigned to work as case managers for high risk and/or high cost Medicaid beneficiaries. Once the QI model is operational, it will become available for statewide health improvement efforts regardless of payer type or insurance status. ALMA will develop, test, and implement an online health network; a web portal accessible by authorized providers within AL and other Gulf Coast states.

## ARIZONA

The Medicaid Health Information Exchange Utility Project includes the development and implementation of a web-based health information exchange (HIE) utility to give Medicaid providers instant access to beneficiaries' health records via electronic connection at the point of service. The EHR will include patient demographics and eligibility information, patient problem lists, medications, lab tests orders/results, radiological results and images, inpatient discharge summaries, and clinical notes. Beneficiaries will have access to their own health information, including immunization records, MCO and provider quality of care information, cost of care information, medications lists, and member case management and patient services plans. MCOs will provide necessary provider training and orientation to HIE/HIT and, as necessary, internet connectivity. The HIE utility will support chronic disease management by providing nearly real time episode-of-care data.

## DISTRICT OF COLUMBIA

The Comprehensive Medicaid Integration Project provides a Patient Data Hub (PDH) service. The six health clinics currently implementing a Practice Management and EMRs capability will integrate with the repository already in use at four of the key hospitals in the District in a Central Medical Records Repository. All relevant DOH programs and systems will also integrate into a Medical Patient and Client Records sharing capability – populated into a Medical Information Integration System (MIIS). Medicaid patients' medical information (in linked systems) will be accessible via web based at the point of care including clinics, hospitals, school nurses, DOH facilities, and Medicaid care managers for analyses, studies, evaluations, care and outcome management, and care cost management.

## HAWAII

Hawaii plans to facilitate the use and adoption of EHRs by clinics and clinicians through the establishment of the Hawaii OpenVista ASP (Application Service Provider) Network (HOVAN). HOVAN will be established as a non-profit and initially connect six clinics, including a federally funded HIV clinic, federally funded geriatric center, two FQHCs and three Native Hawaiian Health System providers through telemedicine lines funded in part by the Universal Service Administrative Company. The ASP model will be used to maintain individual clinic EHRs on centrally located servers that can be accessed via each clinic's computer workstations. They also plan to implement an Imaging interface with ConnectWeb, used by the Hawaii Health Systems Corporation and develop preventive care and chronic care monitoring templates for use with the HI OpenVista. Training in the use of HI OpenVista will be provided by University of Hawaii physicians and clinical application coordinators.

## KENTUCKY

The Kentucky Health Information Partnership (K-HIP) will develop a common web portal for payor-provider communications and include two main areas of functionality: a claims-based patient health summary with clinical information for providers at the point of care and a site for standardized electronic administrative transactions, including eligibility verification and benefits, claims submission and prior authorization verifications, and requests. Leadership from Medicaid, the Kentucky Employees Health Plan, Passport Health Plan of Louisville, Humana Inc., Anthem Health Plan, United Healthcare, CHA Health, Bluegrass Family Health, and Connect Kentucky. A non-profit organization assisting the state with technology adoption, agreed to pursue the development of the common web portal. Plans call for including data from Medicare, self-insured plans, or indigent care, availability of disease management information for provider

query, laboratory and diagnostic results, durable patient registration information, allergy information for provider query, and drug formulary information.

## **MINNESOTA**

The Communication and Accountability for Primary Care System (CAPS) project will create an interoperable, user-friendly, web-based system that will enhance PCP offices as true medical homes for the coordination of care for Medicaid clients with complex health care needs. The system will facilitate communication between the state, PCP, enrollee, and other providers involved in the enrollee's care. Examples of the real-time capacities of this communication tool: the physician reports outcome measures, which trigger monthly performance payments to state; the state communicates an enrollee's medical and drug utilization history to the physician; the health plan physician reports Encounter Data to state; the physician requests prior authorization for services and reports key medical facts to state; the state then communicates an immediate answer to the request for authorization; the state communicates required practice guidelines or outcome measures to physician; providers and team members communicate care plan and actions taken to one another, and the provider communicates care goals and educational information to the enrollee. Capacities include "smart" prior authorization, P4P, enhanced medication therapy management, enhanced enrollee accountability for self care, and ability to host an online clinical care plan. The provider will be provided with utilization history via claims and administrative history.

## **MISSISSIPPI**

The As One-Together for Health project will build a new statewide provider-centric, patient-focused electronic health highway for sharing health data with Medicaid, other state agencies and providers both during times of disaster and during times of normal care that enables hospitals, nursing homes, medical needs shelters, public health, and others to share real-time event status – including the existence of, and/or need for staff, supplies, and other resources. The system will address cross border. The core of the system to be adopted by Mississippi is the Advanced Incident Management System (AIMS), a system currently employed by Alabama. AIMS optimizes the management of surge capacity and surge capability and has the ability to serve as a knowledge portal to access existing e-health records of patients. AIMS will be a core web portal to other tools and functions and will take a dual use (daily and in disasters) approach.

## **MONTANA**

Through the Enhancing EHR – Clinical Decision Making project, MT will provide evidence-based health guidelines in support of the existing Medicaid Management Information System (MMIS) web portal. The Montana MMIS web portal has become the single point of entry for all MT health care stakeholders to access MT Medicaid. With this addition, the portal will securely house information about the overall health status of each recipient as monitored against published national disease guidelines as well as provide needed individual recipient-based EHR. The full clinical decision support suite, enhanced with e-prescribing and automated prior authorization, will support: measurement for adherence to nationally established treatment guidelines for 40 major diseases and conditions; provision of medical and medication histories to pharmacists and providers with the proper authorization; provision of e-prescribing capabilities; provision of automated prior authorization; health interventions by pharmacists at the point-of-care (point-of-sale); medication risk reduction; information to and identification of high-risk recipients; and identification, measurement, and reporting on effective practice patterns.

## NEW MEXICO

The EHR Project will leverage the existing NM MMIS and web portal applications and allow NM to implement a HIPAA privacy rule compliant web portal medical history application. This application will enable authorized providers to view real-time service information on virtually all Medicaid claims for a recipient, paid or denied, extracted from the MMIS and loaded on the portal, as well as diagnosis and treatment information. Implementation of the EHR in NM would provide ER and urgent care staff with key medical information they need to make appropriate treatment decisions. The practitioner will have information on diagnosis, labs and radiological procedures performed, and will know what prescriptions the client should be taking and when they were last dispensed. This will provide patients with an enhanced level of protection from adverse events and reduce the number of duplicative tests and procedures. Providers will enter their provider number to access the enhanced web portal, which will provide real-time, claims-based medical history transaction information, populated through interfaces with the MMIS. Through the web portal, the provider will have access to information on services used by the client by date of service plus procedures, diagnosis and prescription information. The provider must verify recipient identifying data (name, date of birth) before proceeding to the medical history details. The NM Medicaid program will seek input from other health payers in the state to ensure there is a common framework for what is provided in the health record so that the concept is transferable not only to other payers but other Medicaid agencies as well. The state will use elements common in Medicaid Management Information Systems to build the record, allowing replication in other states.

## TEXAS

As a part of comprehensive medical services delivery model for children in foster care, Texas is implementing a Health Passport for Foster Care Children, an EHR that will function as an easily accessible, web-based record of medical and administrative information related to each foster child. The Health Passport will serve three groups of customers – foster children and their caregivers, healthcare providers, and Department of Family and Protective Services (DFPS) staff – by providing portability of healthcare data, improving continuity of patient care, expediting access to needed services, reducing medical errors, enhancing service coordination, and improving healthcare outcomes. The enhanced EHR system will integrate historical claims-based data with ongoing accumulation of clinical data generated by direct care providers. This enhanced system will be able to search, manipulate and present data in formats that optimize value. Enhancements would include medical and behavioral health treatment notes and assessments, forensic data for cases of extreme abuse, monitoring of compliance with Texas' Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT), and e-prescribing functionality. A built-in e-prescribing function will allow physicians to submit prescriptions electronically to pharmacies and receive electronic prior authorization in real time.

## WEST VIRGINIA

The Healthier Medicaid Members Through Applied Technology project is designed to transform the current fragmented, disjointed system to a member-managed, integrated, pro-active system. The initiative will transition the health records of 251,000 Medicaid members from paper to electronic format including the integration of information on healthy lifestyles, health status and risk, disease self-management, and proper use of available health resources. Health records will be linked through an interoperable system that protects privacy. Integrated and electronically connected health care teams will use integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals. Under this initiative, the Medicaid program will provide enhanced reimbursement with a portion of the proceeds of this grant, as a demonstration project in

preparation for P4P for those participating providers that are able to report designated clinical information to Medicaid's clinical data warehouse. Participating providers using certified HIT will be able to create a continuity of care record for high risk patients that can be shared with local and regional health providers who are also providing care to the Medicaid members. Telehealth networks such as MDTV operated by West Virginia University or WVTHN operated by the Network will be used to coordinate consultations for high risk patients. A continuity of care record based upon the standards recommended by the American Academy of Family Physicians will be created through web-enabled interoperable technology by participating providers or regional networks that will give other health care providers much needed information about a participating Medicaid member's medications, allergies, problem-list, recent treatments and lab tests. These systems are being designed to also accommodate Medicaid's "personal healthy rewards accounts" contemplated in conjunction with personal responsibility agreements for enrolled Medicaid members. Personalized health plans will be tracked through the certified electronic health information systems contemplated as part of this initiative.

## WEST VIRGINIA

The Healthier Medicaid Members Through a Stronger Medicaid Program will enable Medicaid to become a more pro-active program that is focused on member health rather than simply enrollment and claims processing. By creating a clinical claims data warehouse, the Medicaid program will build a foundation that will improve the health of Medicaid members. This transformation will create a sophisticated integrated health assurance organization that uses health information and clinical data, risk stratification, disease management and predictive modeling approaches to prevent disease and detect strategies to improve health and member lives. As a result of this effort, it is anticipated that regional networks of providers (medical homes and networks of Advanced Medical Homes) will be connected to the Medicaid agency's data warehouse so that complete health information can be exchanged to permit both the regional systems and the Medicaid agency to engage in population-based health management and predictive. It is the intent of the program to more effectively manage the care and conditions of Medicaid members to reduce the prevalence of these chronic conditions or the complications that lead to loss of life, a reduction in the quality of life and greater utilization of health care resources by Medicaid members.

## WISCONSIN

The goal of the Health Information Exchange is to create a regional health information exchange framework, infrastructure and system to enable multiple hospitals, clinics, and health care institutions to rapidly and securely access medical history information about patients enrolled in the Medicaid and General Assistance Medical Programs (GAMP) in Milwaukee County. Access to patients' medical histories across health care providers will help to reduce redundant tests and procedures, improve health care outcomes, and reduce health care costs. The project is one component of Wisconsin's 5-year road map for adoption of HIT and health information exchange (HIE).

### ***Healthier Medicaid Members***

## WEST VIRGINIA

The Healthier Medicaid Members Through Health Systems Improvement project will transform the primary care delivery system into a network of connected Advanced Medical Homes that apply the chronic care model to provide pro-active patient-centered preventive and chronic disease care. Advanced Medical Homes will utilize an interactive electronic health management system with integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines, and health self-management goals.

Ultimately, the regional Advanced Medical Homes will be connected to the Medicaid data warehouse which will enable the system to engage in population-based health management and predictive modeling. The Mountain Health Choices Health Improvement Institute will prepare community health care providers to qualify as Advanced Medical Homes for Medicaid members and to participate in performance-based health outcome incentives under the P4P demonstration concepts. Qualified providers will be certified as Advanced Medical Homes by the Office of Community Health Systems for the Medicaid program. In addition, an Advanced Medical Home will maintain a centralized comprehensive record of all health-related services needed to provide continuity of care. These networks are expected to function regionally to coordinate care of Medicaid members and to arrange referrals and access to specialty care in concert with the member's medical home. The Medicaid program has pre-certified three community health centers that have been involved in a demonstration project to implement this care model over the past year.

## **WEST VIRGINIA**

Healthier Medicaid Members Through Personal Responsibility is focused on member agreements, member education, healthy rewards and personalized health care. Components of the WV Medicaid redesign include the development of a data warehouse; EHR implemented by pilot clinics; education and outreach to members with member agreements; development and implementation of P4P; development and implementation of an automated pharmacy PA system, including web portal; enhancements to the data warehouse foundation for interoperability; MITA expansion planning and implementation; training and credentialing of pharmacists for use of treatment guidelines, and implementation of a point of sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.

### ***Medicaid Estate Recovery***

## **INDIANA**

The Medicaid Estate Recovery Centralization and Automation Project will improve the effectiveness and efficiency of estate recovery through centralization of Medicaid agency functions, the use of automated systems to conduct data matches, standardization of procedures, and the application of new technology. One data extract and three data matching projects will be initiated: a data extract from the eligibility system to identify a non-Medicaid recipient spouse including name, address, county of residence, DOB, SSN and telephone number; a match of Medicaid recipients aged 55 and over against the Department of Health vital statistic records (death certificates) to identify all Medicaid recipient deaths, including former recipients not on Medicaid at the time of death and the surviving spouse of deceased recipients upon his/her death; a data match of Medicaid recipient data, surviving spouse and former recipients not currently on Medicaid against the local courts electronic docket to identify probated estates and trusts; and a data match of Medicaid recipients against the Attorney General's Office unclaimed property data base.

### ***Medical Information for Children***

## **NEW JERSEY**

The New Jersey Electronic Medical Information for Children (NJ eMedIC) project will develop a web-based system that will have information close to real-time on EPSDT services that children covered by Medicaid have received. The availability of this data to providers on a HIPAA-compliant web-based interface will inform and enhance provider's ability to identify needed services in accordance with the recommended periodicity schedule of screening and treatment services. The web-based system will make blood lead screenings of Medicaid children available to providers and reduce missed opportunities as the providers will be informed of needed services

when the children have an encounter (visit) with them. The system will include features that allow the input of pertinent data (e.g. blood lead levels, case management data of lead-burdened children) and the generation of pre-defined reports that can facilitate monitoring of progress with respect to benchmarks and goals. NJ eMedIC will be a HIPAA-compliant web-based system that organizations (primarily HMOs) can access through the internet to obtain information on children enrolled in their plan. The HMOs will have the capability to extract the information for dissemination to contracted health care providers. NJ eMedIC will inform providers of dates of service of visits (medical and dental) or tests, if a child belongs to a special needs category, a child needs a blood lead screening or is lead-burdened and needs case management services, any known chronic conditions, e.g. asthma, diabetes, immunizations received (from claims and immunization registry), and child's address and race. It will act as an information portal from which EPSDT guidelines, provider newsletters, policies, and reference material for clinical protocols can be obtained.

### **Pharmacy HIT Tool**

#### **CONNECTICUT**

Anchored by a collaboration between Connecticut's decision support system, and Connecticut's Health Information Exchange Organization, Connecticut Health Information Exchange and E-Prescribing Initiative (HIE/EPI) will provide e-prescribing capability to a limited number of licensed health care providers in order to increase use of generic drugs and adherence to the preferred drug lists. The Connecticut HIE/EPI will begin by focusing on Connecticut's non-dual eligible Medicaid population, but will eventually expand to all Medicaid beneficiaries. Licensed health care professionals (LHCPs), pharmacies, hospitals and payers will use this system to share current patient diagnoses and medications, gain access to preferred drug lists, and promote safety through sharing of documented previous allergies and adverse effects. Initially, the state will create a Medicaid Recipient Profile (MRP) with data from the Medicaid Management Information System (MMIS) using recipient identification numbers and names to establish the master person index, demographics, diagnosis, and medications. In addition, the system will be constructed to allow providers to enter allergies. E-prescribing will provide LHCPs with "real-time" clinical decision support tools at the point of care to assist with clinical drug decision-making. The system will be bi-directional in nature in that when patients need refills, the pharmacy will send the prescriber electronic renewal requests, and the prescriber will be able to approve or deny the request electronically. The e-prescribing initiative will proceed once the initial HIE exchange system has been built, which will be approximately six months following project initiation.

#### **FLORIDA**

General Rx Expansion, which builds on the success of the Florida Medicaid program to support electronic prescribing, takes advantage of the upcoming availability of generic products to: treat patients using six specific drug classes, particularly those with diabetes or hyperlipidemia; provide the patient with a 10 day starter pack of generic medications during the office visit; electronically transmit the prescription for the generic product to the patient's pharmacy; provide a base for tracking whether compliance with treatment guidelines improves through closer communication between prescribers and Medicaid pharmacists; and increase the use of e-prescribing capability by participating prescribers. The e-prescribing programs have been modified to allow the prescriber's support staff to renew or refill the "starter" medication with authorization. The renewal or refill of the "starter" medication will be sent electronically to the pharmacy of the patient's choice. The timing of the transmission of this renewal could be at the initial office visit or delayed for up to 10 days based upon the patient's response to the new medication.

## NEW MEXICO

The e-Prescribing project will develop the qualitative, technological and collaborative infrastructure needed to modernize the prescribing process through utilization of new technology to develop electronic prescribing networks. The project will include technical modifications to New Mexico's Medicaid Management Information System (MMIS) and Medicaid Prescription Drug Claims System (PDCS) to enable: e-prescribing capabilities; collaboration with key stakeholders to ensure that the needs of Medicaid providers, recipients and systems are represented in statewide e-prescribing initiatives; and education and incentives to Medicaid providers, including rural, non-profits, FQHCs, and Native American tribal providers to e-prescribe. Technical enhancements will be made to the MMIS and PDCS to ensure prescribers will be able to access information concerning benefit limitations, pharmacy co-payment amounts, application of preferred drug lists (PDLs) or formulary restrictions, generic drug alternatives, prior authorization requirements for drug items, potential drug interactions, recipient drug allergies, therapeutic duplication, and drug over- or under-utilization. The project will work directly with the New Mexico Prescription Coalition (NMPIC), a statewide e-prescribing workgroup brought together by the New Mexico Medical Review Association (NMMRA) New Mexico's Medicare Quality Improvement Organization (QIO).

## NORTH DAKOTA

The Web-based Electronic Pharmacy Claim Submission Interface for Pharmacy Claims project will provide a solution for pharmacies without an National Council for Prescription Drug Programs (NCPDP) claims billing system, eliminate the need for ND Medicaid to process paper pharmacy claims, decrease the error rate in pharmacy claims submission by this set of providers, and identify abuse/inappropriate utilization at the point of service. This project will provide a virtual pharmacy claims processing system for all providers currently without their own system. They will enter their claims on a web site instead of on a paper claim. In less than three seconds, they will then receive a response on the same web site giving the result of the transaction and any drug use review messaging so the pharmacy can complete the delivery of care to the patient.

## TENNESSEE

The Tennessee Electronic Prescription Pilot project will target 50 PCPs in small rural counties to allow them to utilize an electronic prescribing system. The program will provide computer technology along with training and technical assistance. TennCare currently pays the pharmacy benefit manager \$8 per prior authorization (PA). Increasing e-prescription utilization rates in provider practices will lower TennCare expenditures by reducing the need for PAs. E-prescription technology will lead to fewer overrides by TennCare MCOs and greater efficiency in provider practices.

## UTAH

Through the Developing a Utah Pharmacotherapy Risk Management System with an Electronic Surveillance Tool (Utah ePRM) project, Utah will develop a Medicaid Pharmacotherapy Risk Management System with an electronic tool (ePRM) to support medication therapy and risk management services and conduct innovative multi-pronged interventions that are guided by the ePRM trigger tool. The ePRM tool will be used to identify potential drug-therapy problems; select patients and providers for in-depth clinical reviews and possibly direct intervention (i.e., letter, phone call, Medication Therapy Management Services (MTMS), or Academic Detailing); identify potential fraud and diversion of controlled substances; and track patterns of medication use and evaluate ePRM performance, identify improvements, and direct policy change. Clinical areas chosen for review include diabetes therapy, hypertension, asthma, antipsychotic therapy, pain management (opioid narcotics and anticonvulsants) and anticoagulation/antiplatelet drugs.

Clinical pharmacists and physicians will implement five types of inter-related interventions: provider level reviews; patient level reviews and letters to prescribers for high-risk patients; phone consultation and Academic Detailing with outlier prescribers; MTMS for approximately 600 high risk patients; and detecting and pursuing suspected fraud and abuse cases.

## **WEST VIRGINIA**

Healthier Medicaid Members through Enhanced Medication Management will establish an automated prior authorization system which allows the pharmacist to submit claims through a point of sale system and thereby significantly reduce costs. A web portal will be added to allow prescribers and pharmacists to view medical and pharmacy claims as they are submitted. A clinical rules engine will alert prescribers of clinical expectations and pharmacy management issues. This initiative will enable pharmacist to complete patient profiles, allow for the identification of chronic disease that is not being treated according to evidenced-based guidelines, and help to prevent the progression of chronic disease. The pharmacist will be integrated into the care team of the Medicaid member and will provide point of sale assistance to the member in preventing and managing the care of chronic disease.

By automating pre-determined clinical algorithms, routine prior authorizations can be issued through the POS system. This technology will support enhanced POS processing and aid in Preferred Drug List maintenance and support, screen for inappropriate quantities of medications prescribed, early refills of medications, patterns of fraud and abuse, and will support the Pharmacy Lock-In Program.

### ***Predictive Modeling System***

## **ILLINOIS**

By building a sustainable predictive modeling system, the state will be able to establish a rich analytical dataset and build an infrastructure that supports far-reaching data analysis and predictive modeling campaigns. IL will use this capability to improve care for asthmatic patients, identify collusion among psychotherapy and non-emergency transportation providers, and provide for an innovative data distribution system to share the results with stakeholders. The state's Medicaid program will be able to address new target areas with actionable analytical results and prepayment strategies that will enable IL to prevent or reduce the incidence of treatment or payment errors. The focus of this system will be to more rapidly and accurately detect fraudulent activity and increase recoupments, improve the detection of quality of care problems and improve treatment among Medicaid recipients, lessen the burden on legitimate providers who face unnecessary review due to dated methods of selection, and prevent fraud and quality of care issues from occurring in the first place. The foundation for the predictive modeling system currently exists in IL today through an abundance of accessible data found in a robust Data Warehouse, Surveillance Utilization Review System and Case Tracking System. A wide range of sources, including vital records data and all-payer hospital discharge data will be used to construct a state-of-the-art analytical dataset. The completed infrastructure will be designed to facilitate predictive modeling and data analysis and will contain at least several hundred variables for tens of thousands of providers, payees and recipients.

## **KANSAS**

The project Using Predictive Modeling Technology to Improve Preventive Healthcare in the Disabled Medicaid Population will improve the provision of quality preventive health care services and the quality of monitoring for chronic conditions. Targeted case managers in pilot sites will be provided with a computerized, claims-based querying system tool (Impact Pro) to use Medicaid claims data to ensure screenings and preventive care opportunities are not missed.

Case managers from selected Community Developmental Disability Organizations (CDDOs) and Community Mental Health Centers (CMHCs) will be invited to participate. Proposed preventive health care quality measures include: cancer screening (cervical, breast, and colon); cholesterol screening; drug/alcohol abuse screening; and depression screening. Monitoring of chronic conditions will include diabetes, follow-up after hospitalization for mental illness, asthma medication use, antidepressant medication management, and psychiatric medication monitoring. Actual measures used may vary depending upon baseline examinations of the data. During the intervention period, case managers will receive newsletters reinforcing the algorithms and covering new such as nutrition topics prepared by the Kansas University Medical Center faculty. KUMC faculty will also be available via email to answer specific questions from the case managers throughout the intervention period.

### ***Program Integrity***

#### **MARYLAND**

The Automating Fraud and Abuse Tracking / Automated Reporting Program Integrity initiative will modernize and automate the electronic systems used by the investigative units of the Maryland Medicaid Integrity Program. The proposed system will accept data from the existing Surveillance Utilization & Review Systems (SURS) but will create all new cases, make assignments to investigators, and track the improvement of management of case workflow as cases are processed, i.e. reviewed, investigated, recovered, closed. The system will allow investigators to store the documents, records, and images attached to the case and/or investigation in an electronic format. In addition, the system will create and store reports and/or evidence packages with all pertinent documents. The system leverages the Medicare/Medicaid OIG Provider Sanction Database and DEA Revocation Database with automatic cross-referencing capability that notifies the investigator when a prior sanction/revocation exists. Also, the system will enable personnel traveling to field offices to use an Internet-capable portable computer to access the system through a fully-functional web interface. Finally, the system will provide managers with full reporting capabilities to allow a new level of control and insight into daily operations. The system will be fully operational with all staff trained within six months from the beginning of the project, thereby allowing the system to potentially achieve a positive payback within the first year.

#### **NEW YORK**

The NY State Finger Authentication at Point of Service project would require that at the time of service, a provider swipe the recipient's Public Assistance/Medicaid card, and the recipient would put a finger on a small scanning machine to authenticate that the card holder (established at enrollment) is the person getting the service. The authentication would be accomplished by sending the unique card ID and the fingerprint data obtained from scanning to a central site for comparison to the fingerprint data corresponding to the card number. Based on the comparison, a response would be returned indicating whether the individual present at the location was the same individual enrolled for that card number. The use of biometrics builds on the 1.7 million recipients who have already been fingerprinted for Medicaid/Public Assistance and virtually eliminates recipient card loaning and identity theft. The smartcard activation process eliminates transportation and work schedule barriers, providing activation opportunities at as many locations as there are Omni 3750 biometrically-enabled providers.

## ENDNOTES

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<sup>1</sup> Adapted from Texas Health and Human Services Commission, Texas Medicaid in Perspective, Sixth Edition, January 2007, pp. 3-11, 3/12.

<sup>2</sup> A. Gauthier and C. Clancy, "Consumer-driven Health Care: Beyond Rhetoric with Research and Experience," Health Services Research Special Supplement, Vol. 39, no. 4, August 2004.

<sup>3</sup> "Innovative Medicaid Integration Pilot Project Shows Improvement Over Two Years," DSHS press release, January 26, 2007, [www1.dshs.wa.gov/mediareleases/2007/pr07006.shtml](http://www1.dshs.wa.gov/mediareleases/2007/pr07006.shtml).

<sup>4</sup> Center for Medicaid and State Operations, CMS, State Health official Letter #06-003, April 6, 2006

<sup>5</sup> Section 6021: Deficit Reduction Act of 2005.

<sup>6</sup> Inpatient and outpatient hospital, physician, laboratory and x-ray, well-baby and well-child, and other preventive services.

<sup>7</sup> See Status of Federal Approval and Implementation documents on the state's website at: <http://www.healthandwelfare.idaho.gov/site/3629/default.aspx>.

<sup>8</sup> Age-related benefits besides EPSDT, include vision and hearing services available to only those under the age of 21.

<sup>9</sup> Children, pregnant women, the institutionalized, and those receiving hospice services served through Global Choices are not subject to cost-sharing. Plan amendment #06-006 Attachment 4.18-A.

<sup>10</sup> Walls, J. and Kirchner K. *KYHealth Choices and the Deficit Reduction Act of 2005*; November 28, 2006. Prepared by HMA for The Foundation for a Healthy Kentucky.

<sup>11</sup> The state's reform document states that members who have opted-in to ESI may reapply for Medicaid services after 90 days. However, the SPA does not include this provision.

<sup>12</sup> For this purpose, the SPA cross-references the new Social Security Act Section 1937(a) (2) (B) which specifies the eligibility groups that a state *may not* mandate to receive an alternative benefit package.

<sup>13</sup> Benefit structure is taken from the state's website as revised 1/12/07. The state amendment indicates a different benefit structure.

<sup>14</sup> For a discussion of benefit design and cost impact see Cyanne Demchak; *Major Changes in Benefit Design: A Plausible Way to Control Costs?*; Issue Brief for State Coverage Initiatives; Vol.IX, No.6, November 2006.

<sup>15</sup> Deficit Reduction Act of 2005, Section 6044 (1)(B). The Act was signed on February 8, 2006.

<sup>16</sup> See Sachs T. *HIFA at Age Two: Opportunities and Limitations for States*; Issue brief State Coverage Initiatives; November 2003, and Artiga S. and Mann C. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*; Kaiser Commission on Medicaid and the Uninsured; 2005.

<sup>17</sup> Sweeney T.; *Reforming Healthcare Brief #4: Medicaid Buy-In Programs for Individuals with Disabilities*; Georgia Budget and Policy Institute; August, 2006.

<sup>18</sup> U.S. General Accounting Office; *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities*; Report to Congressional Committees; June 2003.

<sup>19</sup> Ibid. Many of those with Medicaid coverage were in medically need categories and required to spend down their income to qualify for Medicaid.

<sup>20</sup> Black W., Liu S., and Ireys H. *How Much are Medicaid Buy-In Participants Earning?* Mathematica Policy Research, Inc.; Working with Disability Issue Brief prepared for CMS; May 2006.

<sup>21</sup> In Missouri, only 38 percent of participants reported earned income, the lowest of all states in the study, and average income was below \$6,000 placing Missouri in the group of 9 states ranking below the average for all states.

<sup>22</sup> Missouri Disability Data Table from the 2005 American Community Survey (ACS); Center for Personal Assistance Services; University of California San Francisco: Accessed at [http://pascenter.org/state\\_based\\_stats/state\\_statistics\\_2005.php?title=Disability%20Statistics](http://pascenter.org/state_based_stats/state_statistics_2005.php?title=Disability%20Statistics). Data is based on a survey of households, so the data does not include people living in institutions such as nursing facilities.

<sup>23</sup> Holahan, J. and Cohen M. *Missouri Medicaid Spending Growth: 2001- 2005*; Cover Missouri Project, Report 4 for the Missouri Foundation for Health.

<sup>24</sup> Ferber, J. *Summary of Medicaid Cuts Adopted In the 2005 Legislative Session*; Legal Services of Eastern Missouri; May 23, 2005.

- <sup>25</sup> Source: Calculated from data contained on Missouri Medicaid's website: *Medicaid Expenditures by Large Eligibility Groups Fiscal Year 2006*; Accessed at: [http://www.dss.mo.gov/rr\\_stats.htm](http://www.dss.mo.gov/rr_stats.htm).
- <sup>26</sup> McBride T. *Losing Health Care in Missouri: Survey Results: Impact of 2005 Medicaid Cuts*; The Missouri Association of Social Welfare and the Missouri Budget Project; March 2006.
- <sup>27</sup> See A Medicaid Buy-in Program Would Increase Health Care Access for the Uninsured But Also Increase State Costs; Office of Program Policy Analysis & Government Accountability, Report No. 05-62; December 2005.
- <sup>28</sup> Section 6062 of the DRA.
- <sup>29</sup> Under the HIFA initiative, CMS has granted states broad authority to restructure their Medicaid and SCHIP programs by limiting enrollment, modifying benefit structures and increasing cost-sharing for some groups. In exchange for this flexibility, states are expected to expand coverage and are encouraged to maximize the use of premium assistance programs that help beneficiaries purchase private sector coverage.
- <sup>30</sup> Newhouse, Joseph, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.
- <sup>31</sup> Wong MD, et al. *Effects of Cost-sharing on Care Seeking and Health Status: Results From the Medical Outcomes Study*. American Journal of Public Health. November 2001. Vol. 91, No. 11.
- <sup>32</sup> Cohen Ross, D. and L. Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage for Children and Families*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2004.
- <sup>33</sup> Ferber, Joel. *Measuring the Decline in Children's Participation in the Missouri Medicaid Program*. March 2006.
- <sup>34</sup> McConnel, J. and N. Wallace, "Impact of Premium Changes in the OHP," The Office for Oregon Health Policy and Research, February 2004.
- <sup>35</sup> Center on Child and Family Health, "Results of Rite Care Premium Follow-up Survey," Rhode Island Department of Human Services, January 2003.
- <sup>36</sup> Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report, July-August 2003," Utah Department of Health, August 2004.
- <sup>37</sup> Additional premium increases went into affect in Vermont on January 1, 2006. However, legislation has since been enacted that will reduce all existing premiums by as much as 50 percent on July 1, 2007 (Smith, V et. al. October 2006).
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- <sup>39</sup> Ibid.
- <sup>40</sup> Vermont Joint Fiscal Office, "Effects of Medicaid Premiums on Program Enrollment: Preliminary Analysis," April 8, 2004.
- <sup>41</sup> Gavin, N.I., et al. "Evaluation of the BadgerCare Medicaid Demonstration" RTI International, December 2003.
- <sup>42</sup> Smith, V. et al. *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey*, Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, October 2006.
- <sup>43</sup> Kirchgraber K. and Matt Powers, "KyHealth Choices: A Look At the Issues," prepared by HMA for the Foundation for a Healthy Kentucky, June 2006.
- <sup>44</sup> Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the OHP Standard Population," The Office for Health Policy and Research, March 2, 2005.
- <sup>45</sup> Artiga S, et al. *Can States Stretch The Medicaid Dollar Without Passing the Buck? Lessons From Utah*. Health Affairs. March/April 2006.
- <sup>46</sup> Lowe, R.A., et al. "Changes in Access to Primary Care for OHP Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health and Science University ER Data," The Office for Oregon Health Policy and Research, September 2003.
- <sup>47</sup> Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the OHP Standard Population," The Office for Health Policy and Research, March 2, 2005.
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- <sup>49</sup> Ibid.

- <sup>50</sup> A. Gauthier and C. Clancy, "Consumer-driven Health Care: Beyond Rhetoric with Research and Experience," *Health Services Research Special Supplement*, Vol. 39, no. 4, August 2004.
- <sup>51</sup> States receiving Real Choice Systems Change funding include Connecticut, Colorado, Florida, Georgia, Idaho, Louisiana, Massachusetts, Maine, Michigan, Missouri, Montana, and Ohio.
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- <sup>55</sup> Section 6044 of the DRA.
- <sup>56</sup> May 3, 2006: SPA may be accessed at [http://www.cms.hhs.gov/DeficitReductionAct/03\\_SPA.asp](http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp).
- <sup>57</sup> For this purpose, the SPA cross-references the new Social Security Act Section 1937(a)(2)(B) which specifies the eligibility groups that a state *may not* mandate to receive an alternative benefit package.
- <sup>58</sup> The four prescription limit applies to all prescriptions – brand name and generic medications.
- <sup>59</sup> Early and Periodic, Screening, Diagnostic, and Treatment program.
- <sup>60</sup> Judith Soloman, "West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries Health," *Center on Budget and Policy Priorities*, May 31, 2006.
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- <sup>63</sup> Solomon, J. 2006; Citing "Experiences in Receiving Health Care by West Virginia CHIP and Medicaid Families" *The United Way of Central West Virginia Health Care Access Project*, October 2004.
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- <sup>67</sup> November 2006 Monitoring Report, Washington Medicaid Integration Partnership, Washington DSHS Research and Data Analysis Division.
- <sup>68</sup> *Ibid.*
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- <sup>70</sup> "Integration of Medicaid Services to Improve Health Outcomes," *DSHS Fact Sheet*, January 2007.
- <sup>71</sup> Center for Medicaid and State Operations, CMS, State Health official Letter #06-003, April 6, 2006.
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- <sup>73</sup> For more information on HEDIS or CAHPS, see [www.ncqa.org](http://www.ncqa.org).
- <sup>74</sup> P. J. Roohan, "Implementation of P4P and Value Based Purchasing Programs to Improve Quality." *New York State Department of Health*, June 20, 2006.
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- <sup>86</sup> Section 6021 of the DRA.
- <sup>87</sup> Ahlstrom A., Clements E., Tumlinson A. and Lambrew J.; *The LTC Partnership Program: Issues and Options*; The Brookings Institution; December 2004; accessed January 12 at <http://www.brookings.edu/views/papers/200412retirement.pdf>.
- <sup>88</sup> Data is current as of September 30, 2006 in California, Connecticut and Indiana. New York data is current as of June 30, 2006. Data can be accessed on state program websites. CA: <http://www.dhs.ca.gov/cpltc>. CT: <http://www.ctpartnership.org/>. IN: <http://www.state.in.us/fssa/iltcp>. NY: <http://www.nyspltc.org/>.
- <sup>89</sup> Individuals are required to meet the level of care need criteria established under a state's Medicaid program to qualify for LTC Medicaid services, and still are required to use any income, other than a modest personal needs allowance, to offset the cost of their care. In addition, a new requirement under the DRA excludes individuals with home equity in excess of \$500,000 (or \$750,000 at the option of the state) from Medicaid eligibility.
- <sup>90</sup> States that had Partnership programs through a SPA as of May 14, 1993 do not have to meet the new definition of "Qualified Partnership" but they do have to maintain consumer protections no less stringent than those in effect as of December 31, 2005. These states are California, Connecticut, Indiana, Iowa, and New York. Centers for Medicare and Medicaid Services; *Qualified LTC Partnerships Under the Deficit Reduction Act of 2005*; July 27, 2006.
- <sup>91</sup> Ahlstrom et. al.
- <sup>92</sup> For a discussion of these issues, see Feder, Judith; *LTC and Medicaid: The Critical Role of Public Financing*; Georgetown Public Policy Institute for the Center for American Progress; June 2005.
- <sup>93</sup> LTC includes nursing facility and in-home expenditures. Source: Missouri Department of Social Services; *Medicaid Expenditures by Large eligibility Groups: Fiscal Year 2006*; accessed January 15, 2007 at [http://www.dss.mo.gov/rr\\_stats.htm](http://www.dss.mo.gov/rr_stats.htm).
- <sup>94</sup> *An Introduction to LTC Insurance Partnership Programs as Part of an Integrated LTC Policy for Texas*; Accessed January 30, 2007 at [http://www.governor.state.tx.us/divisions/bpp/thcpc/files/LTCfinal\\_1204.pdf](http://www.governor.state.tx.us/divisions/bpp/thcpc/files/LTCfinal_1204.pdf).
- <sup>95</sup> Ahlstrom et al. discuss the various indirect benefits of the Partnership program.
- <sup>96</sup> Social Security Act section 1902(a)(30)(A).
- <sup>97</sup> Social Security Act Section 1903(6)(A). Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section [1902\(a\)\(2\)](#), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.
- <sup>98</sup> 42 CFR 447.272.
- <sup>99</sup> See Section 1923 of the Social Security Act.
- <sup>100</sup> P.L. 102-234.

<sup>101</sup> The demonstration began July 1, 2006 in Broward and Duval counties and will be extended statewide by 2010.

<sup>102</sup> McKethan A. and Joel Menges, *Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion*. Prepared by The Lewin Group for the Medicaid Health Plans of America. November 13, 2006.

<sup>103</sup> Florida Senate Bill 838 (2005).

<sup>104</sup> McKethan A. and Joel Menges.

<sup>105</sup> [www.statehealthfacts.org](http://www.statehealthfacts.org).

<sup>106</sup> In Texas, this program is known as Integrated Care Management. A contract for administration of the program was awarded in January 2007, with scheduled implementation in July 2007.

<sup>107</sup> Medicaid's Disabled Population and Managed Care, Kaiser Commission on Medicaid Facts, March 2001.

<sup>108</sup> Ibid.

<sup>109</sup> "America's Health Care Safety Net, Intact but Endangered," *Institute of Medicine* 2000, <http://www.iom.edu/Object.File/Master/4/118/FINALSAFETYNET4PAGERCOLOR.pdf>.

<sup>110</sup> "Next day scheduling" generally means that appointments are booked only for the following day. Facilities typically use this approach to reduce no-show rates and therefore increase provider and clinic productivity. However, most facilities acknowledge that this approach is typically less convenient for clients, who cannot plan for appointment far enough in advance to arrange for transportation, child care or time off from work.

<sup>111</sup> Minnesota Department of Human Services, Medicaid Managed Care Enrollment Report, January 2006.

<sup>112</sup> Minnesota Disability Health Options, People with Physical Disabilities, Enrollment Charts, January 2006, Minnesota Department of Human Services, July 2006.

<sup>113</sup> "Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities" *Center for Health Care Strategies*, January 2004.

<sup>114</sup> Hospital Carve-Out Model for SSI-related Medicaid Eligibles, Local Officials and Public Hospitals, Overview Meeting, Texas Health and Human Services Commission, May 15, 2006.

<sup>115</sup> Code of Federal Regulations *Section 438: Managed Care 438.206 – Availability of Services*.

<sup>116</sup> Medicaid Managed Care - The Impact of Enrolling Aged, Blind & Disabled Beneficiaries: A National Review of Programs." Pacific Health Policy Group. March 2005.

<sup>117</sup> Florida Medicaid Adult Enrollee Satisfaction: A Chartbook Comparing Managed Care Arrangements and FFS, 2004. University of Florida. Center for Medicaid and the Uninsured (Page 90).

<sup>118</sup> Quality in the Managed Care Environment: The Texas STAR+PLUS Program. [www.ltcu.ucla.edu](http://www.ltcu.ucla.edu).

<sup>119</sup> Does Medicaid Managed Care Affect Access To Care For The Uninsured? *Jessica E. Haberer, Bowen Garrett and Laurence C. Baker Health Affairs*, 24, no. 4 (2005): 1095-1105 doi: 10.1377/hlthaff.24.4.1095.

<sup>120</sup> *Medicaid Managed Care: The Impact of Enrolling Aged, Blind and Disabled Beneficiaries: A National Review of Programs*. Pacific Health Policy Group. March 2005.

<sup>121</sup> Pub. L. No. 105-33, § 4701, 111 Stat. 251, 489; § 4705(a), 111 Stat. at 498.

<sup>122</sup> 67 Fed. Reg. 40989 (June 14, 2002).

<sup>123</sup> HEDIS is a set of standardized performance measures designed by the National Committee for Quality Assurance to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. Many of the performance measures have particular relevance for the ABD population.

<sup>124</sup> *Medicaid Managed LTC*. AARP Public Policy Institute Issue Brief Number 79.

<sup>125</sup> ALTCS Clinical Quality Performance Indicators for Influenza Immunizations/Pneumococcal Vaccinations, Arizona Office of Medical Management, October 15, 2002.

<sup>126</sup> Pneumococcal vaccine percentage rates from the previous study period are listed, but should not be directly compared to the 2002 rate because a change was made in the reporting. In 2001, only vaccines received during the previous five years was accepted; in 2002, a vaccine received at anytime in the member's lifetime was accepted.

<sup>127</sup> Annual Forum Update MSHO/MnDHO, March 19, 2004, Pamela Parker, Minnesota Department of Human Services.

<sup>128</sup> Multi-State Evaluation of Dual Eligibles Demonstration, Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care, Robert L. Kane and Patricia Homyak, Division of

Health Services Research and Policy, University of Minnesota School of Public Health, October 2002 (Revised August 2003).

<sup>129</sup> Disease Management Programs in the STAR MCO program, STAR+PLUS, and the Children's Health Insurance Program, Year 1 Follow Up. The Institute for Child Health Policy. University of Florida. November 2005.

<sup>130</sup> Multi-State Evaluation of Dual Eligibles Demonstration, Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care, Robert L. Kane and Patricia Homyak, Division of Health Services Research and Policy, University of Minnesota School of Public Health, October 2002 (Revised August 2003).

<sup>131</sup> *Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for Calendar Years 2003-2004*. APS Healthcare, Inc. October 7, 2005.

<sup>132</sup> North Carolina Division of Medical Assistance, *Consumer Assessment of Health Plans Survey*. Undated. Retrieved December 28, 2006 from: <http://www.dhhs.state.nc.us/dma/cahps.htm>.

<sup>133</sup> University of South Florida Policy Exchange Center on Aging, Evaluation of the Effectiveness of the Managed Long-Term Programs, 2001.

<sup>134</sup> Florida Medicaid Adult Enrollee Satisfaction: A Chartbook Comparing Managed Care Arrangements and FFS, 2004. University of Florida. Center for Medicaid and the Uninsured (Page 105).

<sup>135</sup> Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities, Susan Palsbo, Phillip Beatty, Pamela Parker, Chris Duff, Center for Health Care Strategies, January 2004.

<sup>136</sup> Texas Health and Human Services Commission, "Behavioral Health in Managed Care: A Review of Texas Medicaid Models" December 2002.

<sup>137</sup> Evaluation of Florida's MPN Program, Final Project Report, April 6, 2004, Christy Harris Lemak et al. Prepared by The Department of Health Services Administration and The Florida Center for Medicaid and the Uninsured College of Public Health and Health Professions, University of Florida.

<sup>138</sup> Medicaid in 2005: Current Trends, Key Issues and Outlook for the Future. Presentation to the National Association of State Medicaid Directors. June 6, 2005. Vernon Smith. Health Management Associates.

<sup>139</sup> Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies. Lewin. July 2004.

<sup>140</sup> Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies. The Lewin Group. July 2004.

<sup>141</sup> Cost Savings in Integrated LTC Systems. California Center for LTC Integration. Policy Issue Brief # 2. December 2003.

<sup>142</sup> Cost Savings in Integrated LTC Systems. California Center for LTC Integration. Policy Issue Brief # 2. December 2003.

<sup>143</sup> Evaluation of Community Care Network of North Carolina Asthma and Diabetes Management Initiatives: January 2000 – December 2002. Ricketts, et al. April 15, 2004.

<sup>144</sup> Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2003 – 2004. APS Healthcare, Inc. October 7, 2005.

<sup>145</sup> Medicaid Managed LTC. Issue Brief Number 79. AARP. 2005.

<sup>146</sup> Agency for Health Care Administration, State Center for Health Statistics. Document Abstract. ER Utilization. January 2006.

<sup>147</sup> A Snapshot of Florida Medicaid. November 2004. Florida Agency for Health Care Administration.

<sup>148</sup> Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2003 – 2004. APS Healthcare, Inc. October 7, 2005.

<sup>149</sup> Medicaid Managed LTC. Issue Brief Number 79. AARP. 2005.

<sup>150</sup> Medicaid "Best Buys" for 2007: Promising Reform Strategies for Governors. Center for Health Care Strategies. December 2006.

<sup>151</sup> Arizona's Community Based Services and Settings Report. 2002. The Arizona Health Care Cost Containment System, The Arizona Department of Economic Security and The Arizona Department of Health Services.

<sup>152</sup> The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry. Office of Program Policy Analysis & Government Accountability. May 2006.

<sup>153</sup> Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2003 – 2004. APS Healthcare, Inc. October 7, 2005.

<sup>154</sup> Because HEDIS is a national data set, it allows for comparison across states. However, caution must be used when comparing different populations (e.g., NF versus those in the community).

## **About Health Management Associates**

Health Management Associates (HMA) is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience and technical expertise to local, state and federal government agencies, regional and national foundations, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

### **Tanya Alteras – Senior Consultant, Washington, D.C.**

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Tanya Alteras has extensive experience analyzing issues related to health care financing and organization in the public and private sectors, expanding coverage and improving access for uninsured populations, and developing cost-effective private-public coverage options. Prior to joining HMA, Ms. Alteras was a Senior Policy Analyst at the Economic and Social Research Institute (ESRI), where she studied state and community-based strategies for covering the uninsured, with a goal of providing stakeholders with a roadmap toward developing and implementing such models in their own states and communities. Her focus was on models that involved new and innovative ways of leveraging scarce public resources with other public and private sector funds, such as premium assistance and “three-way” share models. She has also examined the health care system’s strategies for addressing issues such as lack of access to oral health care, and the rising obesity rate.

Ms. Alteras’ previous experience includes serving as a health policy analyst in the office of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services, where she was a policy reviewer of states’ SCHIP and Medicaid 1115 waiver proposals and plan amendments. She was also a member of the team overseeing a congressionally-mandated evaluation of the State Children’s Health Insurance Program, which included conducting case studies and focus groups in a total of 14 states to understand their experiences with the SCHIP program since its inception.

### **Trey Berndt – Senior Consultant, Austin, Texas**

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Trey Berndt joins HMA with over 25 years of experience with Medicare, Medicaid, and State Children’s Health Insurance Program policy and financing. Prior to joining HMA, Mr. Berndt led Texas’ nationally recognized interagency effort to coordinate the health and human service impacts of Medicare Part D prescription drug coverage. As a senior deputy to the State Medicaid/Children’s Health Insurance director, he led special projects on children’s Medicaid simplification, premium assistance, and intergovernmental health financing. Mr. Berndt has extensive experience with state agency and legislative financing processes and issues, having served for nine years as a senior budget office analyst for the federal revenue maximization group of the Texas Legislative Budget Board. He has specialized experience in educating legislative committee members and staff on complex federal financing issues, including the preparation and delivery of public testimony. Additionally, he has worked on program and budget issues related to graduate medical education, Medicaid long term care service delivery, mental health services, and criminal justice system health care programs for special needs offenders.

### **Danielle Chesher – Research Assistant, Lansing, Michigan**

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Ms. Chesher has been with HMA since 2006. Since joining HMA, Ms. Chesher has assisted health plans with the Medicare Advantage application process and has researched policy, enrollment and eligibility requirements for state Medicaid programs. Ms. Chesher also has experience researching community benefit to local programs to cover the uninsured. Ms. Chesher has used her graphic design skills to create marketing material of employee benefit plans for local municipalities as well as editing and formatting a number of reports produced by HMA senior staff.

Ms. Chesher’s expertise lies in graphic design, including layout, format and display. For HMA she designs marketing material, designs and edits reports, and manages relationships and projects with printing

vendors. She also has great knowledge with various Microsoft Office and other desktop publishing programs including Quark Xpress, Adobe Photoshop, Illustrator and Pagemaker. Previous to joining HMA, Ms. Chesher worked as a graphic designer at a classified newspaper, designing and building display ads, as well as creating the layout of the five daily papers.

**Jason Cooke – Principal, Austin, Texas**

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Jason Cooke is a principal with Health Management Associates with a wealth of experience in the development and implementation of policy and operations for publicly financed health care programs and the administrative systems that support them. Prior to joining HMA, Mr. Cooke capped a 14-year career in Texas state government with the creation and management of the Texas SCHIP program and tours of duty as director of operations for Medicaid and Texas Medicaid director. He is well-versed in managed care and administrative services contracting, having spearheaded the creation of Texas' first fully insured statewide public managed care program in designing and launching SCHIP. Mr. Cooke's expertise in public program change management was developed in the cycles of service expansion and contraction in Texas over the last six years and in the transformation of Texas Medicaid and SCHIP administration into a performance-based culture where measurable results and relentless quality improvement are required at levels – from program and vendor to management and staff. Prior to his service as Texas Medicaid and SCHIP director, Mr. Cooke was responsible for advancing the needs of the Medicaid program with the Texas Congressional delegation.

**DeAnn Friedholm – Principal, Austin, Texas**

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Ms. Friedholm has over 25 years of experience in health and human services policy, budget and administration at the state, federal, local and international levels of government. A former Texas Medicaid Director, she has held numerous leadership positions in state government and the non-profit sector. Ms. Friedholm has a broad range of experience in creating strategies for successfully accomplishing health program improvements, from policy development and financing through implementation.

**Karen Hale – Principal, Austin, Texas**

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Karen Hale is a principal at HMA with over 25 years experience in developing and managing behavioral health, developmental disabilities and other social service programs. She also has experience in strategic planning, program and policy development, community needs assessment and governmental relations in both the public and private non-profit sectors.

**Marshall Kelley – Principal, Tallahassee, Florida**

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Marshall E. Kelley is a principal with Health Management Associates with expertise in the areas of state and federal health care issues involving Medicaid, Medicare, aging and disabilities, LTC, managed care and health care facilities. As a principal at HMA, he has assisted clients with program design, business strategy development and expansion in a number of states. He has also assisted states with Medicaid waiver development, policy analysis and program development. Special interests are managed care, managed LTC, consumer directed care and programs for the uninsured. Prior to joining HMA, Mr. Kelley directed the Florida Medicaid program; directed the Florida health care facility regulatory programs, and served as the director of community-based long-term programs for elders in Florida. Mr. Kelley graduated from the University of South Florida in Tampa, and completed masters' degrees from Indiana University and Georgia State University.

**Theresa Laper Sachs – Principal, Washington, D.C.**

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Ms. Sachs is a nationally known expert on design and financing of Medicaid and SCHIP waiver programs. She has more than 16 years experience in health care, including seven years at the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) where she specialized in Medicaid and the SCHIP. Prior to joining HMA in 2005, she provided consulting assistance to several

states relative to the analysis and development of waiver proposals. Her experience includes policy and budget analysis, legislation, administration, and contract management. She concentrates on policy analysis of health care issues, program development, budget neutrality and policy negotiation, and program implementation. She also conducts focus groups and facilitates multi-faceted work groups. Ms. Sachs also has experience as a legislative analyst for the US Senate Special Committee on Aging, as a program manager for The National Council on Aging, and as director of an Area Agency on Aging, where she spearheaded several initiatives aimed at expanding options for elders with disabilities to remain in their own homes.

**Aimee Lashbrook – Consultant, Columbus, Ohio**

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Aimee Lashbrook is a consultant at Health Management Associates in Columbus, OH. Ms. Lashbrook has a broad range of experience in health law, policy and management. After graduating from law school, she practiced health and insurance law in Michigan for two years. She is very experienced in legal research and analysis and has worked with health care organizations in the areas of insurance regulation, state and federal Medicaid law, certificate of need, the HIPAA Privacy Rule, community benefit and cultural competency. She recently obtained a graduate degree in Health Services Administration from the University of Michigan. Since joining HMA in 2006, she has conducted research and helped advise clients on a variety of topics, including Medicaid managed care, best practices in managing high-risk pregnancies and opportunities for public input in the Medicaid policy-making process. Ms. Lashbrook has also assisted state Medicaid programs in the preparation of Requests for Proposals for new programs and initiatives.

**Kim McPherson – Senior Consultant, Austin, Texas**

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Kim McPherson joined Health Management Associates in 2005. She has over 12 years experience in health care delivery and policy, including positions in commercial managed care, state government and the non-profit sector. She has successfully facilitated statewide coalitions, created public outreach campaigns and analyzed health care data to identify areas for improved quality and efficiency. She has particular expertise in the area of behavioral health policy, in both the public and private delivery systems. Her broad range of experience has given her a well-rounded perspective on health care delivery system operations and issues, allowing her to assist state and local programs, associations and private providers.

**Gaylee Morgan – Senior Consultant, Chicago, Illinois**

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Gaylee Morgan brings experience in Medicaid policy and financing, Medicaid managed care, provider reimbursement, and issues related to FQHCs. Prior to joining HMA, Ms. Morgan was a financial policy consultant for a major academic medical center where she was responsible for developing financial models and analyzing the impact of payment and other policy changes. She was also a health financing analyst with the U.S. Office of Management and Budget (OMB) where she worked with states and CMS on the development of Medicaid 1115 and 1915(b) waivers and analyzed the policy and budget implications of statutory, regulatory and administrative changes in the Medicaid program.

**Nicky Moulton – Senior Consultant, Tallahassee, Florida**

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Nicky Moulton is a senior consultant with HMA. She has over 20 years of experience in a variety of health care and public service settings, including experience both as a public provider and State Medicaid administrator of LTC, institutional and community-based services for persons with varying disabilities and for elders. Ms. Moulton specializes in the development of Medicaid programs for persons with LTC needs including managed, integrated acute and LTC programs, behavioral health programs, and special LTC projects including consumer directed care initiatives and nursing home transition projects. She has written Section 1915(c) and Section 1115 waivers, and assists states, providers and advocacy groups with the design of programs for persons with disabilities encompassing policy analysis and development, funding analysis and development, and implementation.

Ms. Moulton has a BSN and worked previously as a licensed Nursing Home Administrator for a 150-bed SNF/MR, a Certified Biofeedback Therapist, a psychiatric nurse and as executive director of an indigent health care program and environmental support organization.

**Melissa Rowan – Senior Consultant, Austin, Texas**

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Melissa Rowan joined HMA after serving as the Texas Medicaid/CHIP Deputy Director for Managed Care Operations. Ms. Rowan has spent her career in health and human services at the state and local levels and with a national health and human services consulting firm. She has extensive experience in Medicaid and Medicaid managed care. She has successfully managed large-scale Medicaid programs and community-based programs for persons with severe mental illness. Ms. Rowan also offers substantial experience in working with elected officials and consumers of public programs.

**Steve Scheer – Principal, Chicago, Illinois**

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Steve Scheer is a principal in the consulting firm of HMA. Mr. Scheer and the firm specialize in assisting providers, state hospital associations and other clients with concerns regarding public programs or public populations such as Medicaid and the uninsured. He works with governments, hospitals and hospital associations on coverage for the uninsured and Medicaid financing. He also assists association clients with association strategic planning and member satisfaction improvement. Among his projects Mr. Scheer has worked on assignments involving Medicaid financing in 24 states during the past five years. Prior to joining HMA, he served as executive vice president of the Illinois Hospital Association.

**Jenna Walls – Senior Consultant, Indianapolis, Indiana**

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Jenna Walls brings over nine years of experience in Medicaid and other government-assisted programs. Ms. Walls' consulting assistance includes assessment of state and federal Medicaid policy changes and evaluation of state health coverage initiatives for children. Prior to joining HMA, Ms. Walls served in various positions within Indiana State Government, most recently as deputy director of the state's Medicaid program. In this position Ms. Walls was involved in procuring pharmacy benefits management and led a team to implement the behavioral pharmacy management program. Within the Indiana State Budget Agency she served as assistant director for Health and Human Services; Higher Education and Economic Development; and the state's Federal Aid Management unit, which was charged with analyzing and managing the impact of federal budget and legislative initiatives on state programs, including federal welfare reform, Medicaid, DSH, and SCHIP. Following her tenure at the Indiana State Budget Agency, Ms. Walls served as a consultant to the governor's SCHIP Commission responsible for formulating Indiana's SCHIP program.