



State Health Watch

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The Newsletter on State Health Care Reform

March 2009



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Will budget cuts affect access for Medicaid recipients in your state?

A growing number of state Medicaid programs are in a precarious position right now: They're torn between cutting provider rates—for many, a necessary step to balance their budgets—and trying to retain providers to maintain recipients' reasonable access to care.

As of September 2008, Medicaid directors in 39 states reported "some" or "significant" problems with access to care in three areas: Primary care, specialty care, and dental, according to a report from the Kaiser Family Foundation (KFF)'s Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch: An Update on*

Medicaid Spending, Coverage and Policy Heading into an Economic Downturn.

"At its most basic level, access is a function of supply and demand," says Robert W. Seifert, a senior associate at the Center for Health Law and Economics at University of Massachusetts Medical School in Charlestown.

Increased enrollment means more demand, which puts pressure on existing providers to maintain access. "Supply has a number of dimensions, but it is definitely affected by the rates providers are

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Maine eliminates 'cliff' of falling off Medicaid with Dirigo health care program

Maine's "Dirigo" health care reform is appropriately named, after the state's motto meaning "I Lead." "We built our reform on a Medicaid base and made modest expansions to Medicaid, covering parents to 200% FPL," says Trish Riley, director of the Governor's Office of Health Policy and Finance in Augusta.

**Fiscal Fitness:
How States Cope**

The state's program now includes DirigoChoice, a sliding-scale subsidy implemented in September 2008 to eliminate the "cliff" that individuals fell off if they had a little

too much income to qualify but were still unable to afford the full cost of coverage. The program provides coverage to individuals, who would otherwise be uninsured.

"When we began in 2003, Maine had the highest rate of uninsured in New England. By 2006, we had the lowest. Our rate of uninsured dropped while every other New England state's rose," says Ms. Riley.

Ms. Riley also is proud of the comprehensive approach that was taken. "The U.S. spends twice what other developed nations spend on health care, but gets less," she says.

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The Newsletter on State Health Care Reform

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Medicaid access

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paid," says Mr. Seifert. "So, increasing enrollment, especially if coupled with rate cuts, will threaten access. If you try to find your savings by cutting provider rates, then you will lose providers. That is a definite danger. It is definitely a fine line that everybody is walking."

Several states, including California, New York, Nevada, Rhode Island, and South Carolina, adopted Medicaid provider payment cuts for FY 2009, even before the economy worsened significantly, according to a January 2009 KFF report, *Medicaid in a Crunch: A Mid-FY 2009 Update on State Medicaid Issues in a Recession*. According to the report, several state Medicaid directors said they were now looking beyond provider rate cuts, and a few said they expected to run out of cash to pay Medicaid providers during the fiscal year.

In the KFF's September 2008 survey, more than half of states indicated that they expected their enrollment and spending to be higher than what they had projected at the start of the fiscal year, mostly attributed to the downturn.

Rising enrollment adds to woes

According to a January 2009 brief, *Rising Unemployment, Medicaid and the Uninsured*, also from the Kaiser Commission on Medicaid and the Uninsured, an unemployment rate of 7% means that Medicaid and SCHIP enrollment would increase by 2.4 million, and an additional 2.6 million people would become uninsured.

"There are so many more people who are seeking coverage because they are losing their employer-sponsored coverage," says **Robin Rudowitz**, a principal policy analyst for the Kaiser Commission on

Medicaid and the Uninsured, and former Medicaid director in the Office of Legislation at the Centers for Medicare & Medicaid Services (CMS). "The COBRA you may or may not qualify for is often unaffordable to someone who is not working. People are left with few options," she adds.

During the last downturn, federal fiscal relief helped states to avoid deeper cuts to programs and provider rates. "If some states are on the verge of making program cuts, federal fiscal relief could help them avoid making those and manage increased enrollment at the same time," says Ms. Rudowitz.

If access is compromised to a serious extent as a result of budget cuts, a state's provider cuts could even be challenged in the courts, says **Ann Kohler**, director of health policy for the National Association of State Medicaid Directors. "I would not say that we are experiencing access problems due to provider rate cuts," she says. "However, both states and CMS will need to monitor the issue closely."

Ms. Kohler notes that in some cases, advocacy organizations have sued states, claiming that lack of access has resulted in the state not being able to provide services as required under Early Periodic Screening, Diagnosis, and Treatment, a requirement that states screen and treat problems identified in children.

"There are laws that say Medicaid programs have to provide certain things and make care reasonably available. And that can be interpreted as saying that you have to pay reasonably for it as well," says Mr. Seifert.

Not all news is bad

On a positive note, one-third of the state Medicaid directors surveyed in the September 2008 report indicated that the access problem is, in

fact, improving, largely as a result of state initiatives to improve provider rates and address dental access.

“There is a large body of research that shows that individuals with Medicaid have significantly better access to care than those that are uninsured,” says Ms. Rudowitz.

“Kids [on Medicaid] in particular compare quite similarly to individuals with private insurance. They are much more likely to have a usual source of care, to have had a dental visit, and to have had a physician encounter over the last year,” she says.

That said, however, there have been longstanding issues related to provider participation in the Medicaid program for several reasons. “Physicians in particular cite Medicaid payment rates, which are generally lower than commercial rates, as one of the key factors,” says Ms. Rudowitz.

However, Ms. Rudowitz notes that access problems are not specific to Medicaid; work force issues make access to primary care, specialists, and dental care providers difficult for individuals with private insurance as well. “So, Medicaid is fighting similar problems as private insurers in finding enough physicians and dentists to treat Medicaid and privately insured patients,” she says.

The September 2008 report also says Medicaid directors generally perceive that Medicaid enrollees have much better access to primary care than to specialty care or dentists. Nearly half of all states reported that they have good or excellent access to primary care. “So, the issues were more focused on specialists and dentists, where there are issues for those with private insurance, as well,” says Ms. Rudowitz.

During the last economic downturn, virtually every state implemented a whole host of cost-containment measures, including freezing or cutting provider rates.

Subsequent budget surveys done by the KFF in 2007, 2008, and 2009 indicated that many more states were increasing rather than decreasing provider rates. When the economy started to recover in 2005, many states were looking to increase provider rates to make up for freezes or cuts made during the downturn.

Ms. Rudowitz notes that Medicaid rates, which already are lower than commercial rates, were frozen during the previous downturn. “During 2007 and 2008, states were moving forward with some big coverage expansions with efforts to address their rising uninsured population,” says Ms. Rudowitz. “And many states realized they needed to shore up provider participation to have meaningful expansions. But now, here we are back in another economic downturn.”

“Now, as the economy has gotten worse even in the first few months of the fiscal year, states are again looking to cut back,” says Ms. Rudowitz. “And provider rate cuts are often one of the first things that states go to, because there is an immediate impact.”

What are states doing?

Until recently, Colorado’s Medicaid program was seeing shorter wait times for new appointments and increasing rates of provider participation. “So, we were looking to build on high rates of primary care participation by working to expand Medicaid slots. We were looking at recruiting particular specialists that hadn’t enrolled in Medicaid,” says **Sandeep Wadhwa, MD**, Medicaid director and chief medical officer with the Colorado Department of Health Care Policy and Financing.

However, the situation has changed with the economic downturn, which resulted in a 12% increase in the state’s Medicaid caseload. “Our safety net providers

are reporting that they are seeing more clients that are both uninsured and on our public health insurance programs, such as Medicaid and SCHIP,” he reports. “We are also hearing from many of our large providers that new appointment times are stretching out from within a week to over a month.”

Although the state’s Medicaid program has not seen reductions in providers re-contracting, this may be because the rate cuts taken for this year were very small.

“We have increased primary care physician rates over the past three years and had been strengthening our relationship and trust with that community,” says Dr. Wadhwa. “This downturn will likely test that trust.”

Colorado has a state-supervised, county-administered eligibility determination model. The modernization of this eligibility determination model is in the process of being examined, and recommendations for improvement have been collected from private vendors.

The goal is to make it easier for people to apply for public health insurance programs and decrease the number of the uninsured, says Dr. Wadhwa.

By leveraging technology and streamlining the application process, Colorado intends for clients’ eligibility determination to be faster and to have access to services more quickly. Examples of proposed improvements include the creation of a paperless system, more avenues for application submission, and a centralized customer service center.

An accountable care collaborative would fund care coordination and shared outcomes incentives for primary care.

Colorado expects to see improved health status of its clients for metrics such as obesity, functional status, and missed days of school; improved

health care metrics such as lower readmission rates and emergency department visits; and improved cost efficiency. “We anticipate that these programs will increase Medicaid panels with primary care,” says Dr. Wadhwa. “We are also proposing a hospital provider fee, which would cover 100,000 to 200,000 uninsured Coloradans, dramatically improving access to care for currently uninsured populations.”

According to **Emma Forkner**, South Carolina’s state Medicaid director, access is ensured for its managed care beneficiaries by certifying network adequacy. Managed care entities must document adequate access to primary, specialty, and hospital care on a county-by-county

basis. “Each submission is approved and verified by our agency’s staff,” she says. “We continue to see network expansions.”

A variety of measures are used to track access for fee-for-service beneficiaries. In addition to multiple internal reports, Medicaid has partnered with the University of South Carolina’s Institute for Families in Society to assess access to OB/GYN providers.

“These providers were particularly concerned about the rate adjustment the agency was forced to make,” says Ms. Forkner. “We always have to be sensitive to access issues. As yet, we have not seen any indications the rate reductions implemented this fall have had any

effect on access.”

The state’s Medicaid budget has been reduced by \$137 million, or about 15%, since August 2008. “With cuts of this magnitude, there are only three things you can do: reduce rates, eliminate services or cut beneficiaries from the rolls,” she says. “We are now prohibited by a temporary state law from adjusting rates, so the burden of future reductions will be shouldered exclusively by Medicaid beneficiaries.”

Contact Ms. Forkner at (803) 898-2504 or forkner@scdhhs.gov, Ms. Rudowitz at (202) 347-5270 or RobinR@kff.org, Mr. Seifert at (617) 886-8065 or Robert.Seifert@umassmed.edu, and Dr. Wadhwa at sandeep.wadhwa@state.co.us. ■

Fiscal Fitness

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“We have set in place several strategies to bring efficiencies to health care and reduce costs.”

Enrollment has stalled

From the very beginning, rough spots were encountered with funding. Although the original goal was to cover everyone in the state within five years, this was compromised in the initial bill. Although this compromise won the bill strong bipartisan support, it also eliminated some major funding sources.

The original proposal had a fee on insurers, explains Ms. Riley, and those who administered self-insured plans that could not be passed on to premium payers. “We knew that covering the uninsured and the underinsured would create savings from lowering the cost shift from bad debt that is passed on to premiums,” she says.

Ms. Riley says the insurers were given additional tools to negotiate lower rates to “pay” for the assessment. Notably, the original proposal

included a global budget to limit hospital growth. These were “compromised away,” she says, replaced by voluntary targets and a savings offset payment that could be levied only when the state documented savings.

Ms. Riley says the federal Medicaid program proved to be a difficult partner. “We had hoped to use our revenues, pooled at the Dirigo Health Agency, to match Medicaid for those dually eligible for Medicaid and Dirigo, but the feds disallowed it,” she reports.

Implementation challenges further reduced available funding for the program, forcing the plan to suspend enrollment. “We had expected to collect 60% from employers for both the employee and employer share of premiums,” says Ms. Riley. “In the end, we only got the share for the employee, not their dependents. We have been successful, but funding is a problem, so our enrollment has stalled. Enrollment was suspended in July 2008.

Maine’s landmark program was funded by a controversial “savings offset plan,” a fee on insurance

carriers for paid health claims. During the last legislative session, an alternative funding strategy was passed to replace the current savings offset payment with a new—and lower—flat 1.8% assessment on paid claims, and adding modest taxes of a few cents per bottle on wine, beer, and sugared drinks.

“As part of that, we also passed a reinsurance program to bring rate relief to the individual market,” says Ms. Riley. “Sadly, this alternative has been caught up with an anti-tax group and a well-financed campaign from the beverage industry to overturn the taxes.”

In November 2008, Maine voters rejected the beverage tax, leaving the savings offset payment in place with a fixed 1.8% assessment on insurance claims. Thus, the state cannot move forward with its planned reinsurance program with the individual insurance market.

“It is unfortunate that a compromise thoughtfully developed by the legislature and backed by a blue-ribbon commission was overturned,” says Ms. Riley. “But the program continues with the savings offset

plan. And we will continue to work with the legislature and the Obama administration to secure needed additional funding.”

Some hard lessons learned

Ms. Riley says she has learned the hard way that when it comes to enacting coverage expansion, “the devil is in the detail. All parties need to sit together and resolve inevitable implementation challenges,” she says. “Also, funding is always an issue, and we need the federal government to help. True reform cannot be done by the state.”

Despite the current obstacles, Ms. Riley contends that the state’s approach—to address the entire system and look at all costs and inefficiencies—is the right one. “Just paying for the uninsured isn’t enough. We need system reform to assure the most efficient and effective health care system, so all can have affordable, quality coverage,” she says.

Ms. Riley points out that Maine succeeded in creating the foundations for a more cost-effective health care system, saving \$150 million since the program’s inception. This, she says, is largely due to collaborating with Maine’s hospitals, which complied with voluntary cost growth targets, more stringent review of hospital building projects, and covering more residents to prevent uncompensated care. Growth in premiums has slowed from an average increase of 13.2% from 2001-2003 to 6.4%

from 2004-2006.

Even with all the funding problems, Maine has been able to increase its rate of insured residents significantly. Though the number and percentage of uninsured residents has risen in many states, in Maine the number of uninsured has fallen. This is partly due to the provision of subsidized health insurance coverage to moderate income workers through the Dirigo Choice program and the funding for parents of eligible children in MaineCare. Combined, the two programs provided coverage for almost 29,000 individuals since 2005.

“We have an \$838 million deficit in a \$6 billion state biennial budget,” says Ms. Riley. “Our goal is to preserve eligibility. In Medicaid, we are proposing a variety of initiatives around rates, benefit management, and hospital payments. We have put in a \$99 million placeholder, in anticipation of FMAP relief from Congress and the president.”

However, the Dirigo program will continue with its current funding regardless of legislative action, says Ms. Riley.

As for the long-term future of the program, Ms. Riley says it’s needed now more than ever, as demand is only growing in the current downturn. “We will again seek legislation to convert the savings offset payment to a less contentious, more predictable flat assessment,” says Ms. Riley. “And we will redouble

our efforts to bring down health care cost growth as well.”

Unlike Massachusetts, which had \$400 million in federal funds supporting uncompensated care that the federal government allowed the state to use for its coverage expansion reform, Maine had no extra dollars.

“We therefore sought to finance access expansions by reducing cost growth in health care and reinvesting in access,” says Ms. Riley. “We hope to secure different funding that will allow us to open the program to our waiting list, and to work with the new administration to transition Dirigo for the reforms we hope will come.”

In order to maintain or expand the program, the state is hoping to obtain federal matching Medicaid dollars, which was rejected by the Centers for Medicare & Medicaid Services under the previous administration and is currently being appealed.

Ms. Riley says she is eager to share what has been learned over the past six years with the Obama administration. “The issues that played out in Maine—as small as we are—are very similar to those that will affect health reform in the much larger and more complex national arena,” says Ms. Riley. “We have had contact with some of the transition folks, several of whom were consultants to us as we shaped our original proposals here. We remain eager to help in any way we can.”

Contact Ms. Riley at (207) 624-7442 or Trish.Riley@maine.gov. ■

New York Medicaid proposes reforms to improve access

New York’s Medicaid program has identified increased access to primary and preventive care and other ambulatory care services as a priority, says **Deborah Bachrach**, Medicaid director and deputy commissioner of the Office of Health Insurance Programs

for the New York State Department of Health.

New York’s hospital inpatient rates are among the highest in the country and exceed the reported costs of hospital care for Medicaid patients. At the same time, Medicaid rates for ambulatory

care—emergency departments, physicians, clinics, and primary care—are well below costs.

Ms. Bachrach notes that New York ranks high among states on unnecessary hospitalizations—hospitalizations that could have been avoided if New Yorkers had timely

access to good primary and preventive care.

In light of this, the state's Gov. David Paterson has embarked on a multiyear strategy to reform and reduce inpatient rates and reallocate the monies to higher reimbursement rates for ambulatory care providers.

In last year's budget, Gov. Paterson invested more than \$300 million in ambulatory care services, with enhanced payments to primary care providers that maintain weekend and evening hours or practice in underserved areas of the state. Building on these reforms, this year's executive budget proposes to invest an additional \$300 million in outpatient settings, further increasing reimbursement levels for hospital clinics, community health centers, and physicians.

Additional payments will be made to clinicians and clinics that meet medical home standards and provide coordinated care and continuity of care for their primary care patients. "A medical home demonstration will be established to support the development of health care homes in the Adirondack Park area, in order to improve quality and access in this underserved area of the state," reports Ms. Bachrach. "The investment in ambulatory care will be funded with reductions to inpatient rates."

Coverage expansion planned

At the same time, the governor's executive budget seeks to reform the inpatient reimbursement methodology to ensure that inpatient dollars support cost-effective, quality care.

Ms. Bachrach says the goal is to reform Medicaid reimbursement to ensure that Medicaid is paying for the right care, in the right setting and at the right price, and most particularly to ensure that New Yorkers have timely access to primary and

preventive care.

More than 4 million low-income New Yorkers have access to comprehensive health care through New York's Medicaid program, says Ms. Bachrach. Because many families with working parents are uninsured, in 2008, New York expanded its State Children's Health Insurance program, making affordable coverage available to every child in New York.

Currently, an estimated 2.5 million New Yorkers do not have health insurance. "Now, Gov. Paterson will partner with the federal government to expand Family Health Plus to 200% of the federal poverty level, making more than 400,000 additional New Yorkers eligible for coverage," says Ms. Bachrach.

To fund this initiative, New York will request a waiver from the federal government to allow the state to tap into \$30 billion of savings the state has already achieved in the Medicaid program. Ms. Bachrach says because New York's Medicaid reform goals are consistent with those articulated by the new federal administration, she is optimistic that New York will be able to develop "a robust partnership with the federal government to expand coverage, contain costs, and improve quality."

Another proposal that Gov. Paterson is advancing is to expand health insurance coverage for family members up to the age of 29, as 31% of New York's uninsured are ages 19 to 29. Although New York law does not require employers to offer dependent coverage, employers who do choose to offer coverage typically offer parents coverage for dependents through age 18 for everyone, and through age 22 if attending college. Gov. Paterson's proposed legislation expands coverage to family members from ages 19 to 29 regardless of whether they attend college.

"This would be a COBRA-like benefit," says Ms. Bachrach. "Families, not employers, would be required to pay the full cost of the policy. But the policy would cost significantly less, since it would be offered under a group policy, and it would be age-rated. Based on New Jersey's experience, families could expect to pay 20% to 40% less than current COBRA rates."

Goal is to remove barriers

The long-term goal is to remove barriers to coverage until every New Yorker who is eligible for publicly-funded coverage is enrolled. To make it easier for eligible New Yorkers to get and keep coverage, the asset test and the finger printing requirement may be eliminated, as well as the requirement that applicants appear for a "face-to-face" interview.

The proposed budget also would increase the amount of funding available for hospitals, community health centers and community mental hygiene clinics serving increasing numbers of uninsured patients; it also would add \$282 million to the Hospital Indigent Care Pool. Over 50% of those funds will go to subsidize state public hospitals, and double funding for the state's Diagnostic and Treatment Center Indigent Care Program from \$55 million to \$110 million through a federal waiver.

"If successful, we will include community mental hygiene clinics in the program," says Ms. Bachrach. "In addition, we will pay enhanced amounts for clinics and clinicians that meet medical home standards. Finally, we are proposing to increase the indigent care pool to provide greater support to hospitals and community health centers serving uninsured patients."

Contact Ms. Bachrach at (518) 474-3018 or dsb10@health.state.ny.us. ■

What is next for states moving toward near-universal coverage?

Vermont, Maine, and Massachusetts are all front runners in the effort to achieve near-universal coverage. And many state Medicaid directors are planning to follow in their footsteps: As of November 2008, 14 additional states were moving toward comprehensive reform, according to the Kaiser Commission on Medicaid and the Uninsured.

But how will the economic downturn affect these plans? “States like Massachusetts are not interested in going backwards. So they will be trying to hold on to what they have,” says **Robin Rudowitz**, a principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured, and former Medicaid director in the Office of Legislation at the Centers for Medicaid & Medicare Services.

Regarding the 14 states that have announced plans to move toward comprehensive reform, Ms. Rudowitz says these are a “mixed bag. Some states are really committed to moving forward with their health coverage expansion, such as Iowa, which just did a big health expansion for kids. A number of states that did advance that are trying to hold on and not move backward,” she says.

Whether the states can maintain or even expand coverage depends largely on two pieces of federal legislation, says Ms. Rudowitz: What happens with reauthorization of SCHIP, and the economic stimulus bill that is expected to include Medicaid fiscal relief.

In the previous downturn, Medicaid federal fiscal relief was successful in helping states to address shortfalls, avoid deeper program cuts, and maintain eligibility levels—a condition of the relief. The relief, however, was criticized for coming too late to help some states,

which had already made significant budget cuts.

“States are certainly anxious for fiscal relief now,” says Ms. Rudowitz, “especially as governors are developing and releasing their proposed budgets. So, timing is also going to be a factor.” She notes that coverage expansion is difficult to do without providers, as states face a shortage of primary care physicians and physicians failing to re-contract despite rate increases.

Program affects nation

According to **Tom Dehner**, Massachusetts’ Medicaid director, the state’s health care reform law was designed to achieve near-universal access to health insurance. “Our progress, so far, is very encouraging,” he reports. “By every available estimate, our rate of uninsurance has fallen dramatically in a very short period of time.”

More than 439,000 people in Massachusetts are newly enrolled in health insurance plans since the health reform was passed into law in June 2006. “Almost half of those are insured in the private market. This is particularly encouraging and will help to ensure the long-term sustainability of our program,” says Mr. Dehner.

According to an August 2008 report from the U.S. Census Bureau, Massachusetts now has the lowest percentage of uninsured of all states, with a two-year average of 7.8% in 2006-2007. This represents a decrease of 2.4% from the 2005-2006 period.

The number of newly insured includes 72,000 individuals whose primary coverage is through MassHealth, which covers 1.1 million people overall, and 176,000 individuals who now are insured through Commonwealth Care.

Mr. Dehner says the state’s health care reform efforts are even having a significant impact on the national level.

The August 2008 report indicates the national rate of uninsured has decreased by 1.34 million people from 2006-2007. “In our state, the number of uninsured dropped by 317,000. This indicates that Massachusetts is responsible for 24% of the overall national decline, while we account for only 2.1% of the population,” he reports. “This speaks to the impact that individual state actions can have on the national level.”

Obstacles were overcome

Initially, the greatest challenge was creating and starting enrollment in the new health coverage programs in a very short time frame. Mr. Dehner says Massachusetts was “enormously successful” in meeting those initial operational objectives, primarily through collaboration between MassHealth, the state Medicaid program, and the newly-created Commonwealth Health Connector.

“We have been fortunate throughout to have had the strong support of U.S. Secretary of Health and Human Services Michael Leavitt, and through our Medicaid 1115 waiver, we have secured ongoing federal support for our health reform programs,” says Mr. Dehner.

The \$21.2 billion agreement, a \$4.3 billion increase over the current waiver, fully preserves existing eligibility and benefit levels as well as federal matching funds for all programs, including Commonwealth Care at 300% of the federal poverty level. The agreement protects federal matching funds for MassHealth waiver programs for the long-term unemployed, the disabled, and

people living with HIV. It also allows the state to meet all of its health care obligations for the current fiscal year.

The state will be able to meet all of its health care obligations for FY 2009, when the state will be able to claim \$150 million for programs for which it was unable to claim matching funds in FY 2008.

The agreement also expands the Patrick administration's authority to bill for programs in the Safety Net Care Pool, which represents authority for federal reimbursement for Commonwealth Care payments, Health Safety Net spending, and hospital supplemental payments by \$1 billion over the current waiver period.

The federal government has proposed a three-year cumulative cap on Safety Net Care Pool expenditures, instead of the current annual cap. This flexibility allows the state to meet all of its commitments for FY 2009 and to plan ahead to meet all FY 2010 and FY 2011 commitments.

Looking ahead, however, Mr. Dehner says controlling health care costs is critical to ensure that the gains made in access to care are sustainable. "We also need to focus on health care quality, so that the care people get is appropriate to their needs," he says.

In December 2008, the *HealthyMass* initiative was launched. Nine agencies from across state government came together in their roles as employers, purchasers, providers, regulators, insurers, administrators, stewards of public health, and sources of health care financing. The goals are to ensure access to care, contain health care costs, advance health care quality, promote individual wellness, and develop healthy communities by aligning policies across state agencies.

"These state agencies are collaborating to decrease administrative burdens on providers, decrease the impact of chronic disease, and align payments to support primary care and community hospitals," says Mr. Dehner.

Model for other states

"We are keenly aware that other states and federal policy-makers are watching our demonstration closely, as well as our success in dramatically reducing the number of uninsured in such a short period of time," says Mr. Dehner. "It is important to note that Massachusetts had some critical building blocks in place before 2006."

These included a relatively

generous Medicaid program, strong consumer protections in private insurance, and a pool of money to cover some expenses for uninsured individuals.

Ultimately, however, Mr. Dehner says Massachusetts has been successful because of a solid policy design, strong federal support, an efficient operational infrastructure for implementation, and broad support for reform from the public, the advocacy community, and the health care industry.

"Those are components that any fundamental reform effort will need to contain to succeed," says Mr. Dehner. "Policy-makers in other states will need to clearly assess their own system's starting points for expanding health care access."

Like many states, Massachusetts recently has had to make some difficult but necessary budget decisions. "As part of \$1.4 billion in budget cuts across state government, we trimmed \$293 million from our Medicaid program," says Mr. Dehner. "In making these cuts, we fully preserved coverage levels and eligibility for our members, which were our top priority."

Contact Mr. Dehner at (617) 573-1770. ■

Public health, Medicaid QI initiatives find common ground

States are trying to do a better job of aligning their public health goals with quality improvement initiatives in Medicaid, with the goal of increasing efficiencies in state spending.

"Medicaid managed care plans are an important component of state public health efforts," says **Deborah Kilstein**, director of quality management and operational support for the Association for Community Affiliated Plans (ACAP) in Washington, DC. "I expect the drive to meet public health goals will continue."

Medicaid managed care provides access to a guaranteed network of providers, with an emphasis on primary and preventive care services and continuous quality improvement.

"Moreover, ACAP health plans have a long-standing tradition of working closely with community-based providers, including community health centers," says Ms. Kilstein.

Medicaid health plans, says Ms. Kilstein, have worked steadily to raise the Healthcare Effectiveness Data and Information Set (HEDIS) scores submitted to the National

Committee for Quality Assurance for a number of measures related to leading indicators for Healthy People 2010.

For example, the HEDIS scores for the number of children enrolled in Medicaid health plans who received all necessary immunizations increased by more than 50% since 2005, and adolescent immunization HEDIS rates more than doubled between 2002 and 2006.

"Health plans are committed to ongoing quality improvement efforts and will work to further these

gains over time,” says Ms. Kilstein.

While there may have been some tension between health departments and Medicaid health plans in the early days of Medicaid managed care concerning roles and responsibilities, Ms. Kilstein says these issues have been resolved.

“A case in point is lead screening,” she says. “Medicaid health plans have forged partnerships to work collaboratively with state and local public health departments, to ensure that every child is screened in accordance with federal guidelines and provided appropriate treatment and case management.”

In Kansas City, MO, Children’s Mercy Family Health Partners (CMFHP), a not-for-profit safety net health plan owned by Children’s Mercy Hospitals and Clinics, identifies children who require lead screening and does extensive outreach and member education, both by mail and telephone. In addition, ongoing education is provided to primary care providers and community agencies.

Through a focused initiative, CMFHP increased lead screening rates by 34% to 44% in enrolled children aged 6 to 36 months.

CMFHP operates an integrated care system that contracts with the states of Kansas and Missouri to provide health insurance benefits to children and adults who are eligible for Medicaid or the State Children’s Health Insurance Plan. Most local health departments contract with the health plan for reimbursement for the lead screenings, and CMFHP often participates in lead screening events as an educational and community resource. To ensure follow-up, laboratory results are shared between the health plan and the state department of health.

CMFHP then provides ongoing care management to any child identified with elevated lead levels, while environmental assessment and

remediation efforts are coordinated with the state health department. Health plan reporting serves to close the loop for monitoring and oversight purposes.

“We believe the program we have developed in collaboration with the state of Missouri is an example of how the managed care plans and public health can collaborate to achieve better outcomes,” says **Ma’ata Touslee**, CMFHP’s chief clinical officer.

The managed care plan’s role is to coordinate care for children with lead levels 10 or higher to ensure appropriate identification and remediation is in place. “In addition, we are responsible to actively educate our members on the importance of lead screening in children and promote education with our contracted providers,” says Ms. Touslee.

To achieve these goals, CMFHP has dedicated Lead Toxicity Care Managers who work collaboratively with the state, public health departments, providers, and members. Here are some of the functions within the program:

• **For identification and referrals to care management:**

— A monthly report is created on all the identified children within the health plan who have had a lead screening and the results.

— Lead care management activities are entered in the state’s Missouri Health Strategic Architectures and Information Cooperative database for all public health agencies to view.

— The state is notified about any members not on the state’s report who CMFHP has learned have had lead screening and the results of the screening.

— A lead screening is utilized as part of the high-risk obstetrics care management program.

— Members are asked about lead screening compliance when they

join CMFHP, as part of the new member Health Risk Assessment process.

— Additional members who need lead screening are identified by working with Mid-America Head Start.

• **For provider education:**

— A provider Quick Reference Guide was developed on lead screening and billing.

— Periodic lead toxicity articles are submitted to the quarterly provider newsletter.

— A one-hour CE/CEU program on lead toxicity is offered to CMFHP provider offices.

— State Advisory meetings are attended.

— A lead audio series is available on the CMFHP web site (www.fhp.org).

• **For member education:**

— Lead educational packets are mailed to members identified with high lead levels or with no history of recommended lead screenings.

— Home visits and assessments are completed for members who are not currently being followed by one of the state public health departments for lead monitoring.

— Member education is coordinated with local public health departments to ensure members are receiving recommended home visits and environmental assessments, if needed.

— Guest speakers are provided to discuss lead screenings on local radio stations.

— Periodic lead toxicity articles are submitted.

Ms. Touslee says she would like to see the program serve as a model for other states. “We have already used it as a model to implement our lead care management initiative in the state of Kansas, where the state’s program is less structured,” she says.

Ms. Kilstein at (202) 341-4101 or DKilstein@communityplans.net. ■

Oregon, New Mexico seeing good results with public health

Oregon's Medicaid program has implemented a number of programs that further public health goals, according to Katherine J. Bradley, PhD, RN, administrator for the Oregon Department of Human Services' Office of Family Health in Portland.

One program aims to increase the percentage of children identified early for developmental delays. For this initiative, public health, Medicaid, and the Oregon Pediatric Society partnered under the auspices of the national ABCD (Assuring Child Health and Development) Learning Academy, sponsored by the National Academy of State Health Policy. The goal: To clarify the Oregon Health Plan policies regarding reimbursement for developmental screening in the preventive health visit for children under age 10.

"The clarification has led managed care to utilize prevention incentives and increase the use of evidence-based screening tools among its contractors," says Dr. Bradley.

Additionally, a managed care company, CareOregon, teamed with the Oregon Pediatric Society to train and educate providers in private practice and at Federally Qualified Health Centers clinics in the office process for screening and referral, leading to increased referrals to state Early Intervention services.

Evaluation of the pilot program currently is under way, and quality measures for the process and outcomes are still in development. Dr. Bradley says, though, that the project already is showing improvement in Oregon's ability to track the quality of its Early Periodic Screening, Diagnosis, and Treatment program, the child health component of the

Medicaid program, which is administered through the Oregon Health Plan.

Immunization rates are targeted

The Oregon Immunization Program is collaborating with the state's Medicaid program to provide assessments of immunization rates and the state's managed care plans.

These assessments are produced through the Immunization Program's Quality Improvement Program, using data from the Immunization Registry. Each year, these assessments are presented to the medical directors and quality improvement coordinators of the managed care plans, as well as to Medicaid staff. Practices and rates are discussed, and plan-level interventions are identified.

"As a result of this work, the Immunization Program and the managed care plans have collaborated in various ways to improve immunization rates and services to clients," says Dr. Bradley.

Two examples include working to identify and correct data quality and data reporting issues, at the plan or clinic level, and conducting joint trainings of clinical staff from offices that contract with the managed care plans to improve immunization rates and practices at the clinic level.

Sixty-five percent of newborns

and 61% of 1- and 2-year-olds—more than 81,000 children—are eligible for the Vaccines for Children program in Oregon, according to 2008 estimates. "Outcomes from the partnerships between the Oregon Immunization Program, Medicaid, and the managed care plans have the potential to reach a significant amount of children in Oregon," says Dr. Bradley.

In 2008, the Oregon Immunization Program and Medicaid worked together to calculate early childhood immunization rates for Medicaid and non-Medicaid children. Using population-based methodology, statewide and county immunization rates were estimated.

"This project allows for the tracking of immunization rates over time and for the creation of common immunization measures across DHS agencies," says Dr. Bradley.

That same year, Oregon submitted a State Plan Amendment to the Centers for Medicare & Medicaid Services (CMS) for a locally-matched pilot to provide Oregon Health Plan (OHP) coverage for Citizen/Alien-Waived Emergent Care pregnancies.

"CMS approved this, and a 15-month pilot went live in April 2008 in Multnomah and Deschutes Counties for full OHP coverage

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provided during pregnancy,” says Dr. Bradley.

This pilot was a partnership between state Medicaid, county health departments, and community health centers to bring prenatal care to a population that had previously not had access to care.

“While the pilots have been successful, budget limitations do not allow for a statewide expansion with match provided by state general funds,” adds Dr. Bradley.

Program uses school-based clinics

“Salud,” New Mexico’s Medicaid managed care program, and its health plans are collaborating with school-based health clinics (SBHCs) to promote weight measurement and management for children. Salud’s HMOs recognize SBHCs that meet quality standards by credentialing them as providers, which enables them to bill health plans for services they provide to Medicaid clients.

Medicaid managed care companies coordinate with SBHCs around the state to reimburse them for services and also to do disease management.

The program, which began as a small pilot at 10 sites back in 1997, is now in place at 84 sites around the state, with 41 sites approved to bill Medicaid. “The initiative was born out of seeing the value of school-based clinics, because that is where kids really go for the care they need,” says **Carolyn Ingram**, New Mexico’s Medicaid director. “Initially, young children are brought in for regular checkups, but that starts to fade off as they get older. So, school is really the predominant place kids are getting services.”

The program was originally funded through the Center for Health Care Strategies (CHCS) via a separate grant to CHCS from the Robert Wood Johnson Foundation, a nonprofit group in Princeton, NJ.

“It took awhile for it to grow and become what it is today,” says Ms. Ingram. “We have agreed to double the number of school-based clinics in the state, and managed care programs made a commitment to continue payments to those services.”

Children receive preventive care, and for complex cases, the child is referred to a primary care provider in the community. “They work with the family to make sure they get follow-up care,” says Ms. Ingram. “It’s been very rewarding to see a program in Medicaid come to fruition, and see children and adolescents getting better care and having better outcomes.”

Early Periodic Screening, Diagnosis, and Treatment visits at SBHCs rose over the course of the pilot project for adolescents ages 10-18. As a percentage of the whole, the pilot sites provided a larger share of these visits to adolescents than other providers in the pilot site communities.

Obesity, diabetes are targeted

After the SBHC pilot program demonstrated success, a healthcare quality improvement program was implemented called Envision New Mexico, patterned after Vermont’s NIC/Q program. “We expanded it and changed it to make it work for us,” says Ms. Ingram.

The program works with pediatric practices on specific disease management initiatives, currently diabetes, weight measurement, and obesity.

All the managed care companies that the state contracts with, large pediatric practices in the state, the University of New Mexico, and the Department of Health have agreed on all the clinical criteria they will use to control obesity and prevent diabetes.

“The managed care programs participate in this program both financially and clinically,” says Ms.

Ingram. “And we have had good success in starting to control the onset of diabetes and prevent obesity in school-age kids.”

Another very recent initiative involves pay-for-performance for immunizations in children. For several years now, the Medicaid program has had performance measures in place for its managed care companies, holding the plans accountable for meeting certain expectations in terms of plan performance, measured by HEDIS outcome data.

“Our sister agency, the department of health, came to the conclusion that our immunization rates still were not what they needed to be in the state,” says Ms. Ingram. “We had pay-for-performance at the managed care level, but we weren’t seeing the outcomes we wanted. So, we started working with the managed care companies to see what we could do to incentivize physicians. We are going to pediatric practices around the state and working with the managed care companies to create a pay-for-performance initiative around immunizations at the doctor level.”

Ms. Ingram says although it’s still too early to share solid data, immunization rates already have started to increase as a result of the program.

Budget cuts won’t affect programs

For fiscal year 2009, the state already has “trimmed back our Medicaid budget,” says Ms. Ingram. “We have done some cost containment to make sure we are bringing our budget in line with the revenues we have available,” she says. “The legislature and the governor’s office will be redoing that. We will have to see what comes out of that, to see if we did enough cost containment.”

The programs wouldn’t be affected by any of the current cuts, says Ms. Ingram, but “going into FY 2010, we have said everything is on the table. We certainly wouldn’t

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want to cut these things first, because we have seen better outcomes because of them.”

However, although the programs do save money down the road, such as Envision preventing obesity, more short-term results may be needed.

“Unfortunately, when you are doing state budget planning, people don’t care so much about the long-term goal of saving money,” says Ms. Ingram. “It is year by year—how much do you have to support the program this year?”

Ms. Ingram says she has been contacted by other states about these initiatives and expects that more states will move toward this type of coordination across their entire health care system.

“You really don’t have a choice anymore. You are dealing with such limited money and funding, and you want to continue to do initiatives to help save money down the road,” says Ms. Ingram. “So, I don’t think states will be pulling back from those things. I think we will see states grow

more into those areas because you’re going to have to, with tight budgets.”

Future plans are to expand the disease management programs to include additional conditions. “After we get one up and going and start to see outcomes, we’ll move on to the next topic,” says Ms. Ingram. “As a state Medicaid director, you tend to get bogged down in the day-to-day stuff. It’s nice to be able to step back and see a program all the way to fruition—because they really do produce good outcomes.”

Contact Dr. Bradley at (971) 673-0233 or katherine.bradley@state.or.us, and Ms. Ingram at (505) 827-3106. ■

In Brief: Don't wait for CMS move, EDs are told

With the likelihood that the Centers for Medicare & Medicaid Services (CMS) will adopt some or all of the 10 national voluntary consensus standards for hospital-based ED care recently endorsed by the National Quality Forum (NQF), experts advise ED managers to begin preparing now to be in compliance. Besides, they argue, the new measures will help them improve the efficiency and quality of their departments.

“ED managers should respond to these measures through their own local performance improvement programs, review these measures, and begin to follow them in their own institutions—and be on the lookout for groups like CMS to include them, perhaps as soon as 2010,” advises **John Moorhead, MD**, professor of emergency medicine at Oregon Health & Science University, Portland. Moorhead co-chairs NQF’s steering committee on hospital-based ED care. “These measures are not the be-all and end-all, but they are important steps in terms of our long-term goal of ED quality improvement,” he says. ■

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