

Stateline Midwest

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INSIDE

CSG Midwest Issue Briefs 2

- **Great Lakes:** Concerns about return of sea lamprey population lead to Wisconsin bill
- **Education:** Illinois takes steps to improve efficiency in education spending
- **Midwest-Canada Relations:** Aging infrastructure not equipped to handle new border policies
- **Health & Human Services:** Federal study raises concerns about future of Critical Access Hospitals

Around the Region 4

States have big stakes in Supreme Court term; trends in corrections populations and policies

Question of the Month 5

Do states in the Midwest allow local governments to levy local sales taxes?

Capital Closeup 5

A review and comparison of how salaries for state legislators are set in the Midwest

Profile 8

North Dakota Senate Majority Leader Rich Wardner

FirstPerson 9

Iowa Rep. Tom Sands on how and why the state reformed its property tax system

CSG News & Events 10

Legislators take part in Midwestern Legislative Conference's renowned leadership program

Capitol Clips 12

- Kansas gives teens early start in high-need jobs
- Michigan OKs Medicaid expansion with co-pays
- Higher speed limits coming to Midwest
- Illinois adopts new rules for gun sellers, owners

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Small group, big health care bills

‘Super utilizers’ of health care system are major drivers of Medicaid — and state — spending

by Kate Tormey (ktormey@csg.org)

Picture an elderly man who is constantly visiting the emergency room with out-of-control blood sugar levels. His doctors can't figure out why his insulin is failing to control his diabetes and why he keeps ending up in the hospital.

Enter a patient-centered team that starts asking the man questions about his daily life. The team finds out that the man doesn't have a refrigerator to keep his insulin cool; by the second half of the month, his medication isn't working properly. After the man receives a small fridge to store his insulin, his visits to the hospital stop.

This is just one example of the kind of challenge being faced in hospitals all over the country: how to better serve high-need, high-cost patients (sometimes referred to as “frequent fliers” or “super utilizers”). This population tends to have complicated medical needs, such as multiple chronic health conditions, sometimes coupled with mental health or substance abuse issues.

Overall, a mere 5 percent of patients account for about half of all health expenditures in the United States. And the problem is slightly more pronounced in Medicaid, the joint state-federal health program. In Medicaid, 5 percent of beneficiaries account for 54 percent of annual expenditures, and just 1 percent of enrollees account for one-quarter of the costs, according to the U.S. Centers for Medicare & Medicaid Services.

According to the Center for Health Care Strategies, of that high-need 1 percent, 83 percent have three or more chronic conditions, and more than 60 percent have five or more of such illnesses.

Both because these patients are languishing under the burden of serious health conditions and because they rack up such large bills — which are paid for by the state in the case of Medicaid — many state policymakers are looking at ways to better address the care of these “super utilizers.”

According to Dan Crippen, executive director of the National Governors

Association, states' high-cost populations can be broken down into three basic categories:

- long-term care (Medicaid pays for about half of total U.S. costs);
- maternity care and births (Medicaid pays for about half of all births in the country); and
- high-cost, high-need patients, usually with chronic conditions.

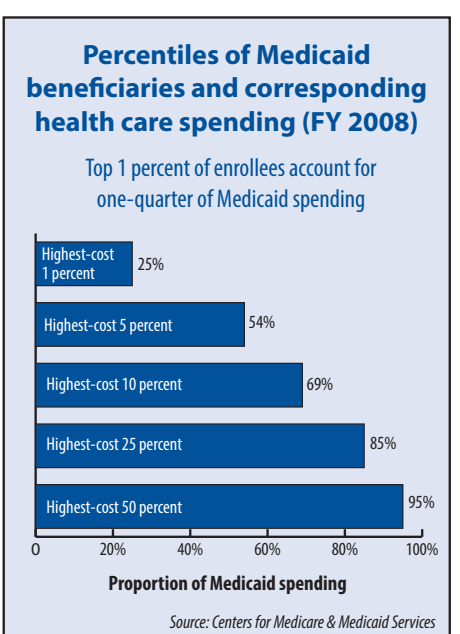
Crippen points out that states are limited in their ability to control costs in the first two categories. (Long-term care and prenatal care must be covered under Medicaid; they are widely considered necessary but are costly.) However, Crippen argues that states have many options to address cost and outcomes in the third category: the “super utilizer” population.

What policy options are available for the region's policymakers?

Health policy experts argue that programs and policies that encourage better-coordinated care for the chronically ill; the addition of “wrap-around” social services; and better integration of mental and physical health care could go a long way toward improving the health of these patients.

“They are less healthy and in need of resources,” he says. “... They end up in hospitals and nursing homes far too often, and there are ways to prevent that by giving them better health.”

The goal of improving care for these patients — and consequently reducing



states' spending on care for them — has become a focus of the NGA. Through a “super utilizer” initiative, the organization will bring together state policymakers to discuss solutions and share best practices. Wisconsin is one of the seven states chosen to participate in the year-long project, which will foster idea-sharing through “policy academies.”

The topic is a good fit for states and for governors specifically, because they have direct purview over many kinds of services — such as nutrition, housing, public health and behavioral health, Crippen says.

The National Association of State Budget Officers reports that Medicaid

► PLEASE TURN TO PAGE 6



About half of all health care spending can be attributed to 5 percent of the U.S. population. Some of these costs are generated by “super utilizers” who end up in emergency rooms and hospitals, usually due to poorly managed chronic conditions. State policymakers are looking for ways to get these patients healthier and bring down the cost of caring for them.

▶ CONTINUED FROM PAGE 1

Best practices: Address chronic conditions, provide more-coordinated health care

spending made up nearly a quarter of state expenditures in fiscal year 2011. State funds dedicated to the program increased 20 percent over fiscal year 2010.

“Health care is driving dilemmas in states because of increasing costs...,” he says. “It’s impeding the ability to fund other priorities, like education or infrastructure. This is a universal problem that begs for solutions.”

So what can states do to better identify and help improve the health of patients with complex needs?

“Health care is driving dilemmas in states because of increasing costs... . It’s impeding the ability to fund other priorities, like education or infrastructure.”

Dan Crippen
National Governors Association

highest-cost patients and began working with them one-on-one: encouraging them to quit smoking, helping them take their medication on time and securing better living situations for them.

With that first pilot population, Brenner was successful in reducing emergency-room visits by 40 percent and cut these patients’ hospital bills by 56 percent. Brenner’s work is an example of how data can be used to identify patterns in health care use and make changes in how patients are treated.

Minnesota is now using Medicaid claims to help providers learn more about their patients. This applies, for example, to providers participating in the state’s new “health homes” initiative. (“Health homes” are providers that agree to take on patients with chronic or complex medical issues, serving as a primary-care facility and coordinating specialist care. In return, providers receive special payments for ensuring that patients receive better preventive care and keep their conditions under control.)

In these new health homes, and in a new set of

coordinated-care pilot projects called accountable care organizations, participating providers are receiving more information about patients.

For example, a “provider alert” report tells a physician if a patient has been in the hospital or an emergency room recently. A “care management report” uses predictive indicators to determine which patients would be candidates for better care coordination (because they are receiving care from multiple specialists, for example).

“Providers are interested and engaged with use on the data, which they can’t get from private plans,” says Marie Zimmerman, health care policy director for the Minnesota Department of Human Services.

Initiatives focus on coordinating care among many providers

Medical and policy experts agree that for many high utilizers, the issue is not *why* they are receiving care — but *where*. A 2010 study by the RAND Corp. found, for example, that 17 percent of all visits to emergency rooms could be treated in other settings, potentially saving \$4.4 billion in annual health costs.

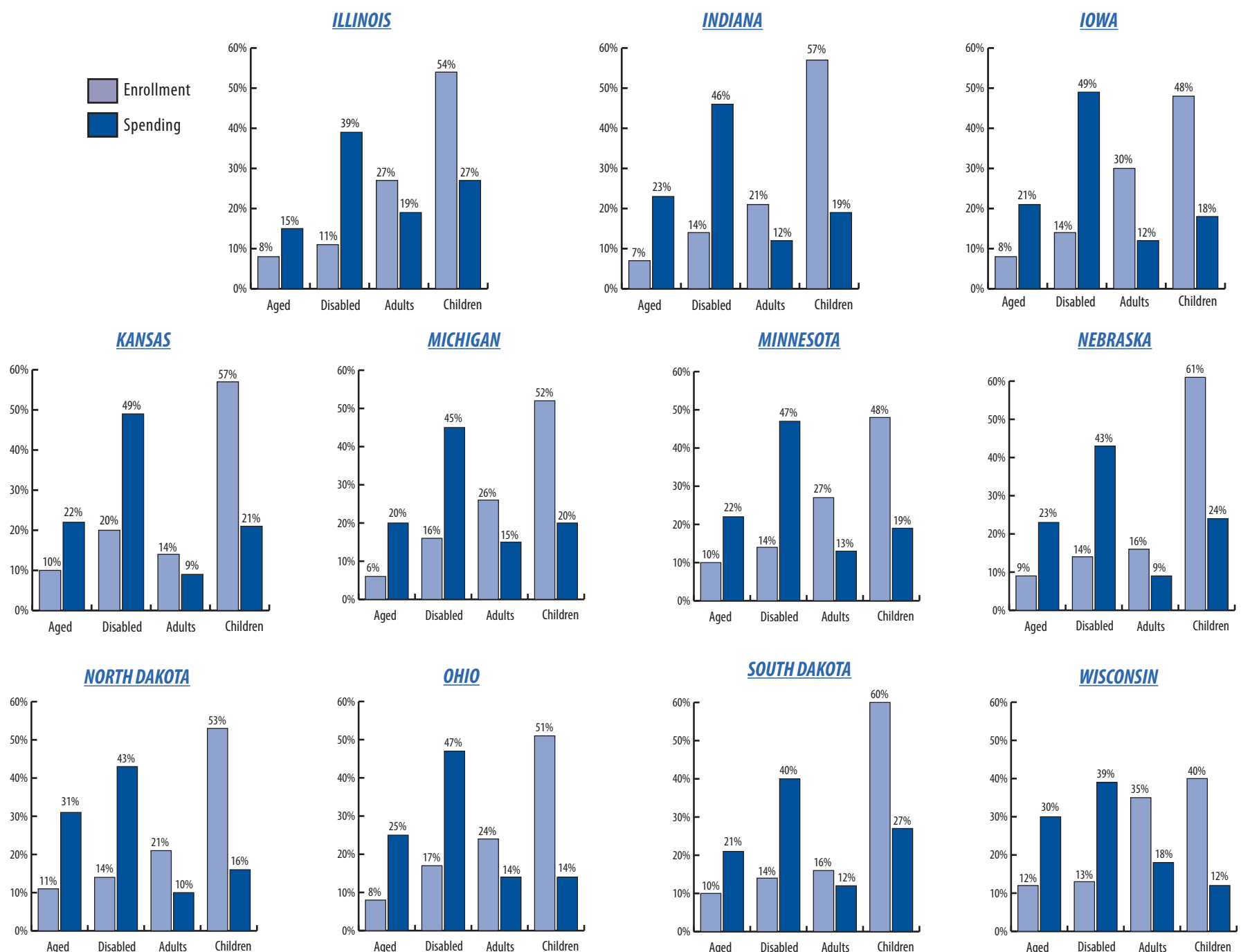
Policymakers exploring this issue are looking at ways to divert patients from the most expensive settings (emergency rooms and hospitals) to those that are more appropriate for their needs. Medical homes, for example, help patients connect with a primary-care provider who can prevent chronic

Claims data can help identify patients who could benefit

The first step to addressing high utilizers is identifying who they are, usually by using data from medical claims.

The concept of “hot spotting” became widely known after a New Jersey physician pored through claims data from hospitals in the city of Camden. Dr. Jeffrey Brenner used the information to pinpoint a few dozen of the community’s highest-need,

Medicaid enrollment and spending in Midwestern states, by enrollment group (FY 2010)



Source: Kaiser Family Foundation

conditions from spiraling out of control. The hope is for patients to need urgent care less often — and to make an office visit for most issues.

Minnesota's Hennepin Health program is widely considered at the cutting edge of programs designed to ensure that patients get regular primary care, with the dual goals of keeping them healthier and reducing emergency-room and inpatient costs.

The program, launched in 2012 in conjunction with the state's early Medicaid expansion, serves the state's poorest residents (under 75 percent of the federal poverty level). Many of them have chemical dependency or mental health issues, according to Scott Leitz, assistant commissioner of the Department of Human Services.

The state contracts directly with the county and provides a "capitated" per-patient payment, without contracting with a third-party health plan. In other words, the county receives a flat fee for caring for a patient — and takes on the risk associated with improving outcomes and reducing costs.



Ohio Sen. Shannon Jones

"That up-front payment helps the county make investments upstream and provide the services needed for patients to be more

stable," Leitz says.

For example, the program studies the 5 percent of patients with the highest utilization rates. The state found that many were continually entering the emergency room for drug and alcohol issues. The county invested in a "sobering center" to divert patients, when appropriate, instead of assessing them in emergency rooms or medical detox centers.

The program also created a coordinated care clinic for 200 of its top utilizers, or those with three or more inpatient stays in the last 12 months. A multidisciplinary team that includes a physician, nurse practitioner, psychologist and social worker cares for a wide range of patients' needs, with the goal of keeping enrollees healthy — and out of the emergency room.

And coordinating care, many experts agree, means reaching beyond the traditional health care system. Sometimes something relatively small, like a refrigerator, can keep a patient out of the hospital and cut medical bills by leaps and bounds.

Crippen provides the example of an asthmatic whose attacks lessened after she was provided with an air conditioning unit. Jones suggests helping someone with healthy-cooking classes to fight the root cause of their obesity. Medicaid does not typically reimburse for many non-medical expenses, so it would generally be a state responsibility to put in place these types of "wrap-around" services. Right now, those services are being provided at the local level in most states — including Ohio, where Jones says the state is "on the verge" of looking at reforms to integrate delivery of those social services into public health programs.

States can also employ the "stick" approach to discouraging patients from going to the emergency

room for routine care. States are permitted to charge fees for non-emergency use of the ER; allowed amounts start at \$3.90 for the poorest beneficiaries but there is no limit for enrollees earning more than 150 percent of the federal poverty level. (Last year, Florida attempted to impose a \$100 fee for Medicaid patients that seek non-urgent care in an emergency room. The measure was rejected by the federal government.)

Payment reform aims to create incentives for improving care

The federal Medicare program has used "accountable care organizations" as a way to improve care coordination and offer incentives for medical professionals who provide quality care.

These arrangements bring together physicians and other medical professionals to care for chronically ill patients who typically see many different kinds of medical providers.

In exchange for agreeing to manage patients' complex medical conditions, the accountable care organization can share in the savings achieved by keeping the patient healthier. (In an ACO, a provider's compensation is typically tied to whether they meet quality measures.)

Through its Health Care Delivery Systems demonstration, Minnesota is currently operating six ACO pilot programs for a total of 100,000 patients.

"Aligning incentives for providers is a much more effective way to [pay for care]," Zimmerman says. "In Medicaid, the ACO is ultimately responsible for [any higher-than-usual] costs and hopefully will benefit from the 'gain share' by meeting the quality targets we have set for them."

While ACOs have already been operating in Medicare and in the private sector, some state policymakers are considering such arrangements in Medicaid. The idea is to move away from the traditional fee-for-service model (in which providers are paid for each visit, test and procedure) — which some experts argue gives incentives for providing more services, not achieving better outcomes.

Ohio Sen. Shannon Jones agrees that the time is now to re-think how care is delivered and how providers are paid. Her state is no different from the nation as a whole, she says: A small group

of people is consuming "the lion's share" of health dollars.

"Instead of thinking about it as health care, we have to think about it as health and wellness," she says. "Prevention is a big piece of that. Let's get people into preventive health care instead of having them come to the ER when there is a crisis."

Jones cites the example of a child with asthma. Instead of continuing to pay for admitting the child to the emergency room with asthma attacks, the money would be better spent on getting the child into a "medical home" and providing services that prevent further episodes.

"How can we intervene in a way that is better for the child in the long run — such as talking about factors such as pets, smoking, carpet and better

Improving health care for high utilizers: Ideas for policymakers

- Offer better care coordination, including designating a medical home to handle care for a patient.
- Change the way providers are paid so that they are rewarded for coordinating care, such as providing extra payment for acting as a medical home.
- Enact payment reforms that allow providers to share in the "risk" of patients' care, such as setting up an Accountable Care Organization that allows professionals to share in the savings when quality care is delivered.
- Treat patients' behavioral health needs as well as their physical needs, and make sure that psychological and medical care are well integrated.
- Address patients' social needs so that they have housing, food and other necessities that give them the ability to keep themselves healthy.
- Use data, such as from medical claims, to identify patients who are high utilizers and why; target them for programs that better coordinate care.

medication management?" she asks.

In recent years, Ohio has ramped up its use of managed care in the Medicaid program, expanding it to more-complex patients. And she believes it's time to take the next step and think about ways to incentivize quality.

For example, everyone wants to see quality indicators such as fewer hospital admissions and an increase in full-term births; providers should be incentivized to help meet those quality indicators.

But, she admits, that is going to be a culture change; she points out that providers are accustomed to being paid for each individual service they perform, and some are concerned about whether their business will be negatively affected under a completely new payment model.

Many of these reforms will have to be achieved through negotiations between the state and its health plans and providers, Jones says. And it might take some time to get the perfect mix of policies, but she believes that in the face of rising costs, states have no option but to commit to reforming the current system.

The NGA's Crippen adds that states have control over not just whether to seek Medicaid waivers for new ideas or how to regulate participating health plans, but many other health policy options, too. For example, states make decisions about scope-of-practice issues — what services health care professionals, such as nurses and dental hygienists, can perform — and how many are trained in their universities. Many experts say this could help improve basic preventive care by creating more access to primary-care providers, and at a lower cost than physicians or dentists.

Crippen adds that state lawmakers have the power to make sure that behavioral and physical health are covered in the same way and in a coordinated manner for patients. All in all, he stresses to state policymakers that they can make a lot more decisions than they think about health care; not everything is dictated from Washington, D.C.

"States have so much power over health care as a purchaser and a regulator," he says. "They can take the reins now and start [making changes]." ★

