

# Stateline Midwest

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## Medicaid makeover

### Premium on quality care, cost savings as states prepare for loss of federal funds and expansion of health program

by *Kate Tormey (ktormey@csg.org)*

Last month, lawmakers in Illinois approved what many are calling landmark reforms to public health programs in the state.

Among the reforms were significant changes to the state's health program for children, All Kids, and the general Medicaid program.

Sen. Heather Steans says the main goal of the legislature's recent actions was simple: address the rising cost of Medicaid at a time when the state faces a \$16 billion budget shortfall.

"Medicaid is a third of our budget," says Steans, a Democrat. "Costs have been rising in Illinois as they have in the rest of the country. We cannot handle our enormous budget deficit without addressing Medicaid costs."



*Sen. Heather Steans*

HB 5420, signed into law in January, includes several cost-saving strategies: cutting down on fraud, addressing the cost of prescription drugs, implementing technological advances to streamline administration, encouraging the use of home- and community-based care and requiring more patients to take part in managed-care plans.

Overall, the legislation is expected to save Illinois at least \$800 million over four years, says Steans, who helped lead the legislative effort. The bill passed both chambers of the legislature with near-unanimous support.

Illinois is not alone in its mission to rein in the cost of Medicaid, which is the second-largest budget item in most states' general funds.

"States' first priority has to be finding a way to get through this fiscal crisis and how Medicaid can be part of the state solution," says Vern Smith, managing principal with Health Management Associates, a firm that works with and advises states on health policy. Smith

previously served as Michigan's Medicaid director.

States are particularly concerned about the cost of the program as they look ahead to June, when enhanced Medicaid matching funds from the federal government are set to expire. According to Smith, the state cost of Medicaid will increase by about 25 percent in fiscal year 2012 — before accounting for any growth in caseloads or increases in benefits, eligibility or provider reimbursement rates.

"The enhanced funding has been in place for three fiscal years and has become part of the [base budget for states]," he says. "Many state officials who have to make these decisions weren't even there in 2008. This is clearly a huge increase in the cost of the program."

What makes the issue even more pressing is another number: 2014. That is the year when the federal government will require all states to expand their Medicaid programs to all residents earning less than 133 percent of the federal poverty level.

This will mean that in each state, thousands of people will become newly eligible for the health program (see table on page 6). In preparation for the expansion,

**Medicaid cost containment actions taken by states in fiscal year 2011**

State	Reduced provider payments	Pharmacy controls	Benefit reductions
Illinois	X		
Indiana	X		X
Iowa		X	
Kansas		X	X
Michigan	X	X	
Minnesota	X		X
Nebraska			
North Dakota			
Ohio	X		
South Dakota	X	X	
Wisconsin	X	X	

Source: Kaiser Family Foundation

states are looking at ways to make their programs more cost-effective. In this article, we look at the recent actions taken by Midwestern states.

### Popular strategies tapped out

In terms of cost containment, most states have used one of two tools to quickly reduce Medicaid costs in a measurable way: restricting eligibility for the program and cutting reimbursement rates to providers.

▶ PLEASE TURN TO PAGE 6



*Medicaid is the second-largest spending area for states, and in fiscal year 2012, the loss of enhanced Medicaid matching funds will increase state costs by an estimated 25 percent.*

▶ CONTINUED FROM PAGE 1

## States seek to get the most bang for their buck when it comes to health care spending

The first method isn't currently available because in order to receive enhanced federal Medicaid funding, states must agree to a "maintenance of effort" provision. In other words, they cannot change eligibility criteria in order to trim Medicaid rolls.

But states can reduce the amount they pay to medical providers who participate in the program.

"The most prevalent cost-containment strategy being used by states in the past few years has been a reduction in provider rates," Smith says. "It's the one strategy that will ensure cost savings."

According to the Kaiser Family Foundation, 37 states reduced reimbursement rates in FY 11, including Illinois, Indiana, Michigan, Minnesota, Ohio, South Dakota and Wisconsin.

Smith points out that all of the "easy" decisions — and even some of the difficult choices — already have been made by states.

So what options do states have to further reduce costs in their Medicaid programs?

Smith says that the next steps being taken by states are geared toward getting the most out of every dollar spent on Medicaid through options such as streamlining administration, improving quality of care, reforming how providers are paid and better managing patient care.

"States are looking at what they can do to get better value and what they can do to improve quality," Smith says.

### Improving program administration

One criticism of health plans is often the amount of money spent on non-medical purposes, such as administration. In fact, under new federal rules, private insurance companies are now required to spend at least 80 to 85 percent of premium dollars on health care and quality improvement.

According to Smith, Medicaid is already much more efficient than that, with a "medical loss ratio" (the percentage spent on non-medical costs) of just 2 to 5 percent.

Still, he says states are working to make administering the program more efficient — and one of the ways to accomplish this goal is through the use of technology.

For example, Wisconsin is considered a model

in this region for its online application system ([access.wisconsin.gov](http://access.wisconsin.gov)) that allows users to apply for a number of different services — such as health coverage, food stamps, child care and other assistance. (The state was the recipient of a CSG Innovations Award in 2010 for its reforms.) State officials say the system has improved data accuracy and decreased the staff time required to process applications.

The Medicaid reform legislation approved last month in Illinois has a provision aimed at helping state agencies coordinate applications and eligibility review. Under the law, state agencies such as the secretary of state's office and Department of Revenue will share information with the Department of Healthcare and Family Services on eligibility factors such as residency and income.

One of the other measures included in the law will allow more administrative and financial flexibility in the state's long-term-care system, with a goal of relying more on home- and community-based care and less on institutional care. The former is less expensive for the state, and studies also show a greater level of satisfaction among patients and families when services can be delivered at home or in the community.

Another goal of the Illinois law is to reduce fraud and the unnecessary spending it causes.

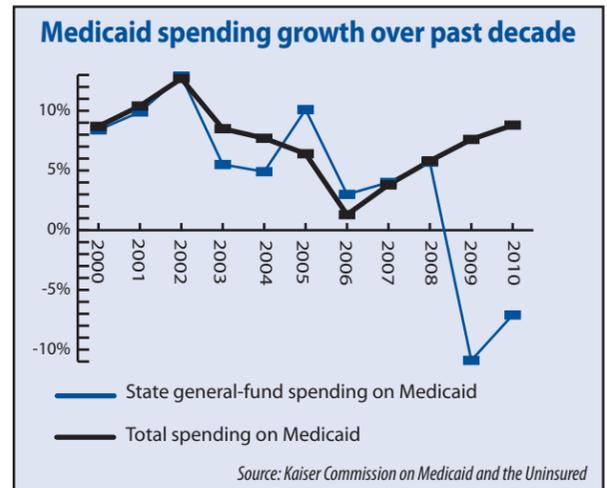
For example, public health programs will now require proof of residency in order to participate. Sen. Steans, who helped lead the legislative effort, says this provision was put in place after policymakers heard anecdotal evidence of out-of-state residents receiving benefits. The state will also have additional authority to prosecute cases of fraud in the Medicaid program. Prior to the new law, the state could only seek criminal prosecution of people who attempt to receive services to which they are not entitled, and those cases were rarely pursued. The state now has the ability to launch civil cases in response to allegations of fraud, Steans says.

"We are trying to make sure we are really cleaning up the way this program is being run and providing services to people who are truly eligible," Steans says.

In addition, the program will now more carefully scrutinize income eligibility for the program; for example, an entire month's worth of reported income will now be required (the program previously required one pay stub). Eligibility for the All Kids program will be limited to families earning less than 300 percent of the federal poverty level. About 3,000 children are expected to become ineligible for the program under the new rules, Steans says; those families will be given a year to find other health coverage.

New rules will also require yearly renewal. Prior to the law's passage, recipients were automatically re-enrolled in the program through "passive renewal." Steans says the new protocol will help make sure people are still eligible for the program before they are cleared to receive benefits.

Iowa is another state in the region working to root out



fraud in the Medicaid system. Last year, the state hired a private firm to examine the program and find inaccuracies or fraudulent activities. The project is expected to save at least \$20 million per year in fraudulent payments.

### Use of managed care

Another trend in state health care systems is the increased use of managed-care plans. Managed care is an arrangement in which states hire a private insurance company to oversee the various aspects of health care in programs.

"Managed care has come to be the go-to delivery system for Medicaid," says Smith.

Usually the state pays a flat fee per enrollee, and the health plan is responsible for handling costs associated with that patient's care.

One of the reasons managed care has become so popular is its predictability in terms of cost. States know upfront how much it will contribute to each enrollee's care, and the risk of additional cost is passed on to the insurer.

In addition, the health plan takes on the responsibility for improving quality and keeping costs down.

"If managed care is incenting providers properly, it should be able to continuously bring down costs," says Minnesota Democratic Sen. Linda Berglin, a longtime leader in health policy and ranking minority member of the Health and Human Services Committee.

The use of managed care has ramped up in the last decade; between 1999 and 2008, the number of Medicaid beneficiaries in managed care doubled (from 17.8 million to 33.4 million). Currently, about 70 percent of all Medicaid recipients are enrolled in a managed-care plan, according to the Kaiser Family Foundation.

That percentage, however, is much lower in Illinois. According to Steans, just 5 percent of the state's 2.8 million beneficiaries are enrolled in managed care.

Under the bill signed into law earlier this year, half of all Medicaid beneficiaries will be enrolled in managed care by 2015.

Managed-care plans often assign a patient to a "medical home," or a primary-care provider that can monitor all of a patient's needs, such as health conditions, medications and needed screenings.

Minnesota's 2008 health care reform legislation included a provision aimed at expanding the state's use of medical homes. Under the program, which began in July, health care providers can apply to become certified health care homes. As of December, 47 providers had become state-certified health care homes and were serving about 80,000

### Additional enrollment and spending attributed to Medicaid expansion

State	Total new Medicaid enrollees in 2019	Additional federal Medicaid spending, 2014-2019 (in millions)	Additional state Medicaid spending, 2014-2019 (in millions)	Percent increase in state spending, 2014-2019*
Illinois	631,024	\$19,259	\$1,202	+1.6%
Indiana	297,737	\$8,535	\$478	+2.5%
Iowa	114,691	\$2,800	\$147	+1.4%
Kansas	143,445	\$3,477	\$166	+1.7%
Michigan	589,965	\$14,252	\$686	+2.0%
Minnesota	251,783	\$7,836	\$421	+1.2%
Nebraska	83,898	\$2,345	\$106	+1.5%
North Dakota	28,864	\$595	\$32	+1.4%
Ohio	667,376	\$17,130	\$830	+1.6%
South Dakota	31,317	\$717	\$32	+1.1%
Wisconsin	127,987	\$4,252	\$205	+0.9%

Source: Kaiser Family Foundation

enrollees of Minnesota's public health care programs (roughly 10 percent of all enrollees).

In exchange for acting as a health care home for beneficiaries with chronic illnesses, providers receive monthly payments based on the complexity of the patient's needs — up to \$60 per month. In addition, payments are increased by 15 percent for “supplemental complexity factors,” if, for example, the patient has a persistent mental illness or his or her primary language is not English.

Studies show that when patients have medical homes, they are more likely to get preventive screenings and better manage chronic illnesses, which can decrease the need for costly medical care in the future.

### Changing how care is paid for

The use of medical-home payments is just one way Minnesota has changed how health care is paid for. The state, in fact, has been a national leader in the area of payment reform.

Lawmakers there decided that relying on managed care alone was not enough. In order to further rein in health care spending, Berglin and her colleagues worked to address costs directly with providers.

“Just because you're paying a [managed-care] company a [set] payment doesn't mean they are passing those incentives on to providers,” she says. “You can have managed-care contracts where plans are

still paying providers on a fee-for-service basis — and you're going to get fee-for-service results.”

As part of the health care reform bill passed in 2008, Minnesota instituted the Quality Incentive Payment System. In the first year of this pay-for-performance program, quality was measured in five areas: diabetes care, vascular care, acute heart attack, heart failure and pneumonia. Providers participating in state health programs and in the state employee health plan who show quality performance and

improvement over time are rewarded with enhanced payments.

Providers are also now permitted to charge one fee for all of the services required to treat one episode or illness. Proponents of this payment model say it will rein in costs by encouraging doctors to provide the best care at the lowest price — instead of the traditional “fee for service” model that compensates providers for each patient visit, test and procedure.

And Minnesota's groundbreaking “peer grouping” initiative will soon help consumers access information about how providers stack up in terms of quality and cost.

“It will be online and used by companies, health care plans and the public programs to help determine where people are getting their care and where the best, low-cost care could be provided,” she says. She adds that the data, which will be publicly available later this year, will help health

care homes recommend the most cost-effective specialists to their patients.

Quality is also a major factor in how Michigan chooses the health plan it hires to cover its Medicaid patients. Smith says that the state decides upfront how much it will pay for the plan each year, and uses quality (instead of price) to rank plans. Each year, the state chooses a health care area in need of improvement — such as prenatal care or child health — and awards contracts to plans that fare the best on related indicators of quality.

Indiana, too, has reformed the way health services are paid for by asking consumers to play a greater role in the cost of their care. The Healthy Indiana program was launched in 2008 to serve low-income, working adults who are uninsured.

Participants receive free preventive care and are given \$1,100 annually in health savings accounts to pay for additional care. Enrollees are asked to pay into the accounts based on their ability to pay. If



Sen. Linda Berglin

consumers need more than \$1,100 of medical care in a year, a traditional insurance benefit kicks in.

As long as participants complete recommended preventive care, any unused money in their individual POWER accounts can be rolled over to offset the next

year's contributions.

Proponents of these types of consumer-based plans say they give enrollees a reward for healthy behaviors that keep them out of the doctor's office — and when they do need care, there is an incentive to find the best care at the lowest price. ★

## “States are looking at what they can do to get better value and what they can do to improve quality.”

Vern Smith

Managing principal, Health Management Associates

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