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IMPLEMENTATION BRIEF 2

Implementation of the Affordable Care Act of 2010

Medicaid Expansion Under Health Care Reform: Promising Approaches to Managing Care for People with Complex Medical Needs

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The Patient Protection and Affordable Health Care Act was signed into law in March 2010. Shortly after the passage of the bill, the University of Maryland School of Public Policy and the IBM Center for the Business of Government came together to create a Blog on the IBM Center's website to address implementation issues surrounding the new law.

The Making Health Care Work Blog focused on the central challenge of the new law: How will the nation implement the massive bill of over 2700 pages? The Blog discussed how the nation can make health care reform work, as well as the challenge of designing important new tools needed for government. While news coverage focuses on the politics of health care reform in Washington, the Blog went beneath the rhetoric to share the difficult details of what state and federal officials have to do to make sure that the law works on the ground.

From analysis to "Q and As" with top officials, the Making Health Care Work Blog remains a source of valuable information about Medicaid expansion, health insurance exchanges, and other top challenges in the implementation of health reform.

Review the discussion at:
www.businessofgovernment.org/blogs/making-health-care-reform-work

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Now that health care reform has been enacted, people have begun working on the details of implementing the new law. The University of Maryland School of Public Policy and the IBM Center for The Business of Government are collaborating to offer a unique voice on the major implementation issues surrounding health care reform. The Implementation Brief series is based on two key premises:

- The battle of the passage of health care reform was just the prelude to even bigger implementation battles to come.
- Making health care reform work is the next great frontier, and we all have a vested interest in understanding the complicated process of turning legislation into a national program that is implemented in a way that works for all.

This Implementation Brief, *Medicaid Expansion Under Health Care Reform: Promising Approaches to Managing Care for People with Complex Medical Needs,* is the second in a series of reports exploring a number of the most formidable and important challenges facing states and the federal government as they implement the Affordable Care Act. The first Implementation Brief, *Modernizing Medicaid: Strategies for Managing Enrollment in Health Care Reform,* presented several new approaches to identifying and enrolling people in Medicaid and CHIP, which is an important goal for the Medicaid expansion scheduled to begin in 2014. This Implementation Brief is the next step in the sequence of challenges related to Medicaid expansion. It presents promising approaches to managing the care of people who will newly enroll in Medicaid and have complex medical needs.

A third Implementation Brief will address another very important challenge: How states and the federal government can best prepare to build and operate Health Insurance Exchanges. These exchanges, which will offer a wide choice of private health plans and sliding scale federal premium subsidies for millions of Americans, are also scheduled to launch in 2014.

This Implementation Brief seeks to contribute to the discussion about the Act's implementation. We welcome your comments and look forward to a lively conversation.

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The Affordable Care Act (ACA) extends eligibility for Medicaid to all legal residents of the U.S. with incomes up to 133 percent of the federal poverty line (FPL).[1] This Implementation Brief features promising models of care management tailored to lower-income populations with complex medical needs, and six approaches to meeting these needs. The Brief places particular emphasis on poor and near-poor adults without dependent children ("childless adults" discussed in box below) who will be newly eligible for Medicaid.

Approximately 14.4 million Medicaid beneficiaries have a chronic illness. Many of these have two or more chronic conditions. This frequently leads to decreased quality of life, lower productivity, and major limitations in activity. It also results in a large amount of federal and state government spending: approximately 83 percent of Medicaid spending is dedicated to people with multiple chronic conditions.[2]

Newly eligible childless adults present a wide array of complex medical and social needs. Referring to the preparation for enrolling newly eligible people under ACA, the Center for Health Care Strategies notes that "…many newly enrolled adults are likely to have multiple chronic health care needs, including mental health and substance abuse. In the absence of effective care management and care coordination, these beneficiaries may either face insufficient access to needed preventive services or potentially duplicative or adversely interacting treatments. Either path could result in poor health outcomes, otherwise preventable hospitalizations, and high levels of medical expenditures."[3]

Eligibility for Medicaid

Parents with dependent children are eligible for Medicaid if their income falls below the eligibility standard in their state (these standards vary widely across the states and in the majority of states, fall below the federal poverty line, or FPL). In a few states such as Massachusetts and New York, parents with incomes below the ACA threshold of 133 percent of poverty are already eligible for Medicaid. In other states, such as Florida and Texas, very large numbers of these parents are currently ineligible for Medicaid and would be newly entitled to Medicaid coverage under ACA.

Low income adults without dependent children, sometimes referred to as "childless adults," have been traditionally excluded from Medicaid eligibility. Some states have received waivers from the U.S. Department of Health and Human Services to cover low-income childless adults, in most cases those with incomes below the poverty line. Thus, in most states all of these adults with incomes below 133 percent of the FPL will be newly eligible for Medicaid.[4]

This Implementation Brief focuses on promising practices and new approaches to serving low-income childless adults because most of the states do not have experience serving this high-need population. Most states do have experience serving lower-income parents and children (though many states will have to cover more of them under ACA), and this population, on the whole, tends to be relatively healthy.

A study by the Kaiser Commission on Medicaid and the Uninsured found that low-income childless adults frequently have limited English proficiency, lower education levels, and literacy challenges that can make completing the enrollment process difficult. Latinos and other non-native populations may face language and cultural issues that can serve as enrollment barriers.[5] Further, about one-third of childless adults with family incomes at or below 133 percent of the FPL have been diagnosed with a chronic condition, and over 60 percent of uninsured childless adults in this income group have no usual source of care, which can make it difficult for them to access needed care and less likely that they will receive preventive care. For example, about one-third of these adults have not had their blood pressure checked in the past two years, even though this low-cost screening can detect hypertension before it leads to disability or death, and among those with a chronic condition, more than four in ten did not have a doctor's visit in the past year.[6]

Thus, states should consider developing and refining care management practices that address the needs of newly enrolled patients. Yet, these interventions may require some up-front investments, and this may be challenging in the current fiscal climate.

Promising practices that focus on new ways to provide care to high-need Medicaid patients are now emerging in a variety of states around the country.

North Carolina. Community Care of North Carolina (CCNC) targets diabetes and asthma as widely prevalent and costly diseases among the state's Medicaid population, based on a review of the Medicaid claims data. Using CCNC, North Carolina has built a ground-up system of community health networks that are organized and operated by local physicians, hospitals, health departments, and departments of social services. Through private, not-for-profit networks, the program is implementing the local systems that are needed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients.

There are fourteen (14) CCNC networks with more than 3,000 physicians across North Carolina working with their local community providers and agencies to better manage the care of over 745,000 Medicaid enrollees. The program works directly with community providers who have traditionally cared for North Carolina's low-income residents and builds private and public partnerships where community providers can work together to cooperatively plan for meeting patient needs and where existing resources can be used most efficiently.[7] Evaluations of CCNC have shown that it reduces emergency room (ER) use and inpatient admissions and thereby reduces spending.

Oklahoma. Oklahoma created the Emergency Room Utilization Initiative to target Medicaid enrollees with inappropriate ER utilization. This includes showing primary care case managers profiles of their patients' ER use rates and how these compare with those of their peers; outreach to identify and assist enrollees with four or more physician visits in a calendar quarter, an indicator of chronic medical problems; interventions such as letters and telephone calls to check patients' conditions; ensuring that everyone has a primary care case manager and access to specialist physicians; and follow-up on nurse call-line calls that direct beneficiaries to the ER, to assess the appropriateness of those recommendations.

Kansas. Kansas does not target specific diseases, as North Carolina is doing, but instead targets high-risk or high-cost enrollees in the state's managed care program.[8] Kansas uses the Johns Hopkins Adjusted Clinical Groups Case-Mix Predictive model to identify patients and stratify members for the care management program. When patients are identified, they are contacted by a care management group called Central Plains that works with the state. Patients get customized care plans that match their needs. Kansas uses an interdisciplinary team of nurse care managers and social service workers. Interventions include in-person and/or telephonic care management, connection with community support, collaboration with the primary care physician, and provider and patient education materials.

Virginia. Virginia targets Medicaid enrollees with congestive heart failure, asthma, coronary artery disease, and diabetes for intensive care management. The state establishes condition-specific benchmarks and uses claims data to develop care plans. The disease management program includes intensive case management, 24/7 nurse advice line, health status assessments, disease education, and patient self-monitoring.[9]

Washington. The State of Washington has two promising care management practices.

- Washington State has focused on people with substance abuse problems, some of whom are homeless. Bad contact information, unstable housing, overwhelming socioeconomic challenges and, in some cases, lack of trust, all intersect to make finding these people, enrolling them in Medicaid, and meaningfully engaging patients with chronic illnesses and mental health and substance abuse issues extremely difficult.

- Washington State is also piloting an intensive care management approach for adults with mental illness and/or chemical dependency and physical health co-morbidities. King County Care Partners, a partnership in the Seattle area of the King County Aging and Disability Services, Harborview Medical Center, and four community health center networks, is implementing a pilot project for roughly 500 fee-for-service beneficiaries.[10]

  The Center for Health Care Strategies (CHCS) *Rethinking Care Program* has found that creative and persistent approaches to locate and engage Medicaid high-risk beneficiaries can increase participation rates and boost the effectiveness of care management programs such as this one. In the southwest portion of Washington State, the Cowlitz Comprehensive Health program serves people in rural and small-town settings. Partners include a federally qualified health center, a mental health center, and a drug abuse prevention center, and they contribute staff expertise and time. The goals are to assist enrollees in improving health status and decrease avoidable health care spending. This initiative started in April 2010 and focuses on intensive outreach to find people who are homeless and without addresses; these are people who do not have phones or will not answer cell phones and frequently do not want to be located.[11]

California. California's experience illustrates the potential for savings from care management approaches. According to a study by The Lewin Group that reviewed 24 studies of Medicaid managed care cost savings, preventable hospital admissions in California were 25 percent lower for Temporary Assistance for Needy Families (TANF) recipients enrolled in Medicaid managed care than for TANF recipients enrolled in fee-for-service arrangements. The corresponding reduction in hospital admissions for the SSI population—Medicaid beneficiaries who are senior citizens or non-elderly disabled people living in poverty—was 38 percent. This research found that nearly all of the studies showed savings from enrolling Medicaid beneficiaries in some form of managed care arrangement. In some studies savings were relatively small, but in others they ranged up to 20 percent. The largest source of savings was a reduction in inpatient hospital admissions.[13]

The Need for Toolkits

As the importance of learning about best practices in Medicaid care management for both adults and children increases, there is a growing need for "toolkits" to make promising strategies and initiatives readily accessible to states.

The Robert Wood Johnson Foundation has developed one such toolkit that presents best practices in Medicaid managed care for improving asthma care for children. The toolkit was developed by the Center for Health Care Strategies based on a work group called Achieving Better Care for Asthma, comprised of 11 health plans serving Medicaid patients. The toolkit includes:

- Developing and using asthma registries (a list of patients with this disease that can be used as a source of data for asthma management by patients and providers)
- Using innovative and persistent methods to reach high-risk patients
- Offering provider education focusing on patient self-management and appropriate prescribing
- Implementing provider incentives to reward high-quality asthma care (e.g. reimbursing providers for conducting member education).[12]

Based on a review of research on promising practices on Medicaid managed care for patients with complex medical needs, the following six approaches seem worth pursuing for serving newly eligible low-income childless adults.

APPROACH 1: Set Clear Goals and Ensure Stakeholder Involvement

The first approach is to set clear goals for developing care management programs, based on the patient mix and characteristics of the population and an understanding of the range of health and social services they require.

Vital to success in this early planning is stakeholder involvement rather than a top-down approach. This can be accomplished through community meetings, focus groups, and other strategies. States should also determine what other states have found useful and what approaches have not worked so well. Thus, a kind of "clearinghouse" of best practices would be helpful.

Further, states should obtain available federal matching support for their efforts to enhance their own funding streams.[14]

APPROACH 2: Assess Needs of Each New Patient and Develop Individualized Care Plans

States should require health plans to make an immediate assessment, or medical work-up, of each new person enrolled in managed care. It is not enough to just hand someone a Medicaid card and place them in a plan. Too frequently, the next time anyone sees that person will be in the emergency room or on a hospital gurney.

This assessment should lead to an individualized care plan customized to the constellation of medical and social needs that each patient presents. There could be stratification of patients by risk and need. Resources should be targeted to the highest-need populations.

The individualized care plans could also incorporate a kind of "contract," under which the patient also has some responsibilities regarding managing his or her own health and avoiding risky behaviors.

APPROACH 3: Integrate Services Across "Silos"

The hallmark of the traditional medical care delivery system is fragmented care with little integration across the spectrum of health services, and even less integration of health and social services. The types of people newly enrolling in Medicaid will include many who present a constellation of varied needs that cross these silos.

A good place to start is by integrating physical health and behavioral health care. This would feature making primary care physicians more aware of the warning signs and symptoms of mental health and substance abuse, and willing to make referrals to mental health professionals and substance abuse treatment facilities.

An additional component of good care plans will frequently involve assistance with nutrition, housing needs, and other social services that fall outside of the health care model even though they clearly affect patients' health.[15]

APPROACH 4: Use Performance Measurement and Health Information Technology

Medicaid managed health care plans should be held accountable for cost and quality. This should include performance measures and public reporting. This would be enhanced by a system of rewards and penalties that aligns incentives to improve health outcomes and functional status.

Many states have moved in this direction by developing pay-for-performance programs under Medicaid and quality indicators related to chronic diseases. These programs reward health plans that score well on various measures of health care quality. This might include, for example, measures related to checking hemoglobin A1C levels for patients with diabetes, use of corticosteroids where clinically indicated for asthma patients, and appropriate use of hypertension medications for patients with high blood pressure.

Health information technology (HIT) can facilitate and reinforce the goal of aligning incentives to improve health outcomes. Better managing care for high-need patients will be greatly enhanced if physicians and hospitals adopt an interoperable system of electronic medical records, and use e-prescribing and computer-assisted physician order entry of medications for patients in hospitals.

APPROACH 5: Improve Discharge Planning and Follow-Up

Too frequently, patients lose contact with the health care system when they leave the hospital, and this leads to serial readmissions, many of which are avoidable with proper follow-up care. There is considerable research evidence showing that intensive, multi-disciplinary hospital pre-discharge planning and counseling, coupled with post-discharge time spent with patients by doctors, nurse practitioners, social workers and nutritionists, can help address this problem. Home visits after discharge, or at least telephonic communication, should feature dietary assistance, medication management, social service support, patient self-management, early symptom spotting, and access to physicians when problems arise. These interventions should be time-intensive, frequent, and individually engage the patient regarding clinical metrics and subjective assessments of conditions over time.[16]

APPROACH 6: Redesign the Delivery System

Better care management will be facilitated by redesigning the health care delivery system. Under the "business-as-usual" system, Medicaid patients frequently show up in the emergency room (ER) for non-emergency care, and there is little or no feedback to their primary care physician. In fact, many patients do not have a regular source of care. Frequently, patients self-refer to hospital outpatient departments for specialty care. Some of these visits are inappropriate, and the medical situation could be handled if the patient had a primary care physician.

A number of U.S. cities are developing community-wide initiatives to redirect people from the ER to a regular source of primary care, either in a community health center or an office-based physician practice. In San Francisco, for example, when a Medicaid patient arrives in the ER in a non-emergency situation, a follow-up visit with a clinic or other primary care site is scheduled at a time when the patient can keep the appointment. The records of the ER visit are immediately sent, either electronically or by fax, to the primary care doctor. A reminder call to the patient is automatically scheduled to help ensure that the new appointment is kept.

Another element of system redesign involves setting up collaborative arrangements across a community in which a number of hospitals and community health centers agree to see a fair share of Medicaid and uninsured patients, rather than placing almost the entire burden on one particular hospital, e.g. a public hospital, which becomes overwhelmed with uncompensated care. In some communities, such as the Austin, Texas area, this is accompanied by the creation of a central repository of data on patient encounters, with information gathered on certain chronic diseases such as diabetes and asthma, which is then used to improve the delivery of services for these populations.[17]

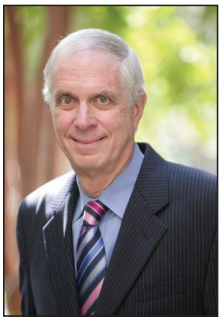
Bringing both parents and adults without dependent children into Medicaid will help an estimated 16 million people obtain improved access to health care and should improve their health. But states will be challenged to develop effective care management plans to serve a population with complex medical needs.

A key challenge is to develop care management plans for people with one or more chronic illnesses. This should include individualized care plans for each patient and coordination among various physicians seeing patients, as well as across the divide between the health delivery system and such important services as nutrition, housing, employment, and transportation. Better hospital discharge planning and follow-up is critical. Performance measurement at the provider level is also important, along with patient engagement.

States and local communities should work with clinics, physicians, and hospitals to redesign the health care delivery system. This entails redirecting patients from repeated use of ERs and hospital outpatient clinics for routine care to a regular source of care in a primary care setting. The use of electronic medical records can facilitate this transition.

The success of these approaches may require some modest new outlays by states. This could be challenging in the current fiscal climate. States may be able to form partnerships with foundations or obtain some federal grants to help them meet the cost of these promising care management practices.

1. The Affordable Care Act encompasses both the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, which amended PPACA. http://docs.house.gov/energycommerce/ppacacon.pdf
2. Arora R., Boehm J., Chimento L., Moldawer L., Tsien C. "Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide." (Prepared by The Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 07-0063. Rockville, MD: Agency for Healthcare Research and Quality; February 2008.
3. Stephen A. Somers and Vivian Byrd. "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." Center for Health Care Strategies Policy Brief. August 2010. p. 11.
4. Medicaid also covers two other populations: people 65 years of age and older who have very low incomes and receive cash assistance from the federal Supplemental Security Income (SSI) program, and low-income, non-elderly adults who meet the federal government's test of being disabled. These two populations, taken together, account for the majority of Medicaid spending, but are not directly affected by ACA.
5. Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences." July 2010. p. 7.
6. Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty." April 2010.
7. http://www.communitycarenc.com/WordDocs/ChronicCareLegislativeUpdate.doc
8. Rhode Island and Oklahoma also follow this approach.
9. Arora et al. supra.
10. Center for Health Care Strategies. "Strategies for Finding and Engaging Medicaid Beneficiaries for Complex Care Management." October 2010. http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261169
11. Shirley Munkberg. "Care Management Approach in Washington." CHCS Rethinking Care Webinar. October 5, 2010.
12. The Robert Wood Johnson Foundation. "Toolkit Outlines Best Practices in Medicaid Managed Care for Improving Asthma Care for Children." June 4, 2008. http://www.rwjf.org/pr/product.jsp?id=28824
13. The Lewin Group. "Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies." March 2009. p. 2.
14. Arora, et al. supra. p. 1-1.
15. Somers and Byrd, supra.
16. Jack Meyer and Barbara Smith. "Chronic Disease Management: Evidence of Predictable Savings." Health Management Associates. November 2008.
17. http://www.icc-centex.org.



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Dr. Meyer's recent publications include "Expanding Health Coverage in the District of Columbia: D.C.'s Shift From Providing Services to Subsidizing Individuals and its Continuing Challenges in Promoting Health," prepared for the Brookings Institution and the Rockefeller Foundation; "The Impact of Federal Stimulus Funding on Health Spending in Florida: Accomplishments and Challenges," published by the Collins Center for Public Policy; "County and City Health Departments: The Need for Sustainable Funding and the Potential Effects of Health Care Reform on Their Operations," published by the Robert Wood Johnson Foundation; and "Chronic Disease Management: Evidence of Predictable Savings," published by Health Management Associates.

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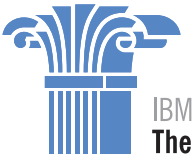

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