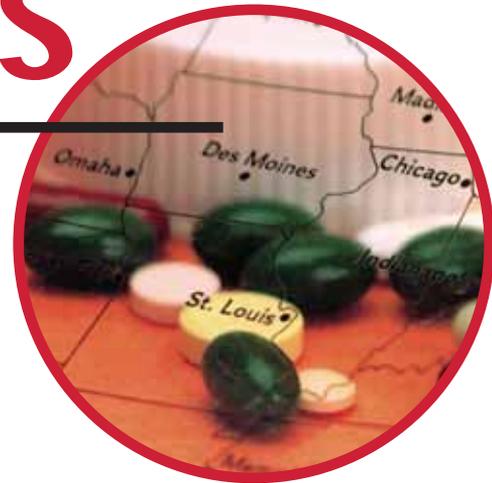


Iowa Leads Medicaid Reform



Tactics will offset losses and expand eligibility

By Tim Anderson

With the state's fiscal situation already tight and Medicaid expenses rising, Iowa lawmakers faced more unwelcome news when they arrived in Des Moines this January.

The state was close to losing \$65 million in federal health care funding. The potential loss involved Iowa's use of a financing arrangement known as intergovernmental transfers. These transfers have been a common practice among states, allowing them and local health care systems to tap into more dollars from Washington, D.C.

But policymakers in the nation's capital, looking to rein in federal health care costs, are on the verge of closing this Medicaid financing loophole.

Iowa, however, found a way to avoid the pending, inopportune fiscal hit. A bipartisan solution reached this year will not only offset the loss of intergovernmental transfer dollars, it also will expand eligibility and introduce several cutting-edge ideas into the state's Medicaid program.

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—Iowa House Speaker Pro Tempore Danny Carroll

“They are breaking new ground,” says Kathleen Gifford, a principal at Health Management Associates Inc., a health care research and consulting organization.

If successful, Iowa policymakers say, the Medicaid reforms will cut costs and lead to a better health care delivery system. Those two potential results, even more so than the prospects of losing federal revenue, helped convince lawmakers to enact the changes, says House Speaker Pro Tempore Danny Carroll, a principal architect of the plan.

“I suppose in some ways the budget challenges of the last three or four years have brought us to this point,” Carroll adds. “Every time we have come into session, the Medicaid budget has been threatening to take the lion’s share. So we want to try and stretch our dollars further.

“But more important than that, at least with me, is addressing ways of better delivering health care. We have been managing things as an emergency room program. We wait until somebody is sick or near death and then step in and say, ‘OK, we’ll pay the bill.’ Why aren’t we encouraging and rewarding people for doing the right thing—disease management, checkups, preventative care and thinking about their health care?”

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Securing Federal Support

To move forward with the plan, Iowa had to seek a waiver from the federal government (final approval was received as of July 1, 2005).

With the waiver, instead of losing the \$65 million in federal intergovernmental transfer funds, the state can use the money for its reform initiative, which includes an expansion of program eligibility. Uninsured residents with income levels of up to 200 percent of the poverty level can now enroll (on a limited basis) in Medicaid.

“We’ll be able to cover between 20,000 and 40,000 more Iowans,” says Senate Floor Leader Michael Gronstal, one of a handful of Iowa lawmakers who traveled to the nation’s capital earlier this year to lobby for the federal waiver.

“We also now have a process in place to expand coverage even more in the future.”

Iowa already has been paying for this uninsured population through state and/or county indigent care programs, but without matching dollars from the federal government. That will change under the waiver agreement.

The state legislation needed to authorize the Medicaid reform plan received overwhelming support in both legislative chambers this year and was signed into law by Gov. Tom Vilsack in May.

“In the end, I think the Legislature saw this as a win-win for Iowa,” Gronstal says.

New Rules and Ideas

As both Gronstal and Carroll note, very different rules will apply to participants in the expanded Medicaid population.

Upon enrollment, members will receive a medical evaluation and personal health care plan. Members’ self-assessment of their compliance with the plan will then be tracked by the state.

“We’ll have incentives for positive lifestyle choices, including smoking cessation and weight control,” Carroll says.

The plan also encourages the use of preventative care. For example, enrollees will need to have a primary care physician and, in many instances, be required to use a nursing hot line before accessing emergency room care.

Members of this expanded Medicaid population also will pay a monthly premium that amounts to 5 percent of their salary.

Medicaid Ideas from Another Midwestern State

Wisconsin

A recently created legislative committee in Wisconsin has initiated its task of trying to find Medicaid savings.

“The real expenses and costs—and therefore the opportunity for improvement and innovation—is in long-term care,” says Curt Gielow, chair of the Wisconsin Assembly Committee on Medicaid Reform. “That is what our committee is going to focus on in the coming months, particularly opportunities to de-institutionalize care.”

The committee also will look at other emerging issues in this area, including encouraging or requiring the purchase of long-term care insurance and more closely scrutinizing cases of asset divestment.

“We’re very concerned about situations in which people have money, they give it to family members, and then they expect the state of Wisconsin to pay for [their long-term care costs],” says Rep. Sheldon Wasserman, another member of the committee.

The Milwaukee representative hopes the state pursues several other ways to contain costs in its Medicaid program. For example, he believes greater scrutiny of durable medical equipment purchases could yield significant savings. He and Gielow also say the state can be more aggressive in requiring use of generic prescription drugs by Medicaid recipients.

The state plans to offer health savings accounts to the expanded population. Enrollees would be entitled to a credit of up to \$1,000 toward any Medicaid-covered service. Any unused money could be pocketed by the enrollee.

The state's hope is that these accounts encourage enrollees to practice healthy lifestyles and avoid costly medical treatment.

"There's an effort, in several different ways, to increase personal responsibility within this expanded population," Gronstal notes.

For instance, enrollees who follow their health care plans or don't smoke would pay lower premiums and co-pays.

Iowa's reform package also includes provider-performance rewards and incentives for employers to offer health insurance to workers in the Medicaid expansion program.

In addition, in an effort to improve the quality of care and reduce avoidable medical errors, the state will expand the use of electronic medical records for Medicaid providers and their patients.

"This is a five-year [federal] demonstration waiver," Carroll says. "And we hope it proves to be a good example of how states can begin to explore innovative ways of managing Medicaid and controlling costs."

Improving the Level of Care

Parts of the plan focus specifically on the expanded Medicaid population, but others impact everyone covered by the public health care program.

Through various incentives and outreach programs, for example, Iowa will attempt to reduce smoking among its Medicaid population to less than 10 percent.

In an effort to improve oral health care, every Medicaid-enrolled child age 12 and under will participate in a new "dental home program." Participants in this initiative will receive the dental screenings and preventive care identified in oral health standards developed by the state.

"We have been suffering expenses later on because children aren't getting good health care," Carroll says.

The reform initiative also calls for a move away from institutional care, both for the elderly and developmentally disabled.

"We want to encourage more home and community-based service," Carroll says.

To do so, the Medicaid reform plan increases the threshold level for admissions into nursing homes and intermediate care facilities for people with mental retardation. The state also will examine ways of amending regulations on nursing homes to allow them to pursue community-based long-term services.

As the various programs under the five-year waiver begin being implemented, a joint legislative committee will be charged with reviewing the various initiatives.

Gronstal says he hopes the reform plan is the beginning of ongoing Medicaid improvements in Iowa.

"For most healthy people, the cost of the program is not terribly expensive," he says. "It's those target populations with expensive, ongoing chronic disease problems that really cost the system a lot of money."

"If we can do a better job of controlling costs in that population, the savings can be pumped back into the system to provide broader care."

—Tim Anderson is publications manager for *The Council of State Governments' Midwest Legislative Conference*.

Medicaid Ideas from Other Midwestern States

Kansas

A bill went through the Kansas Legislature this year that creates a new Kansas Health Authority. In addition to overseeing the state's Medicaid program, the authority—made up of gubernatorial and legislative appointments—will be in charge of various other state health care services.

The most immediate savings are expected to come from improving administrative efficiencies and bolstering Kansas' buying power in the health care market. But long-term pay-offs are also expected.

"We have had multiple parts of state government dealing with health care, but there has not been a single group looking at how we spend our money," Kansas Sen. Jim Barnett said.

"With the authority, we now have a platform for a group to focus on finding efficiencies, scrutinizing spending and developing new health care strategies for the state."

Ohio

Ohio also wants to take a more coordinated approach to Medicaid spending and services. One idea being pursued in that state is to make administration of the program a cabinet-level agency.

Meanwhile, as part of the new budget approved by lawmakers, Ohio will move forward with a slew of other Medicaid reform ideas.

- All families and children covered under Medicaid must participate in a managed care program, eliminating the fee-for-service model. While there will be up-front costs involved in the transition, the state expects to save money both during and after the current biennium.
- Ohio revamped its estate recovery process. With the change, the state can now recover more assets from a deceased Medicaid recipient.
- Several long-term care initiatives have been established in the budget, many of which address the state's goal of encouraging the use of home and community-based services instead of nursing homes. Changes include making assisted living a Medicaid option and improving the pre-screening process for future program recipients. A long-term care resource center also will be created to make the elderly and disabled more aware of their health care options.
- Some of the strategies highlighted in an October 2004 study by the Kaiser Commission on Medicaid and the Uninsured illustrating the wide array of cost-containment strategies being employed by states are also part of Ohio's new budget. Medicaid benefits were changed, provider rates were frozen, eligibility requirements were stiffened, new co-payments for services were created and tougher statutes against fraud and abuse were enacted. In addition, Ohio will encourage greater use of generic prescription drugs and initiate more audits of Medicaid providers.

Many of the recent steps taken in the state reflect recommendations made earlier this year by the Ohio Commission to Reform Medicaid—a group created by the governor and Legislature in 2003.