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Medicaid Policy Changes in Idaho under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges

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LIST OF ABBREVIATIONS

BMI	Body Mass Index
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DRA	Deficit Reduction Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
MMIS	Medicaid Management Information System
PA	Prior Authorization
PCCM	Primary Care Case Management
PHA	Preventive Health Assistance
PCP	Primary Care Provider
SPA	State Plan Amendment

EXECUTIVE SUMMARY

In 2006, Idaho became one of the first states in the nation to implement changes to its Medicaid program under authority granted by the Deficit Reduction Act of 2005 (DRA) (PL 109-171). The policy change initiative, known as Modernizing Medicaid: Value-Based Reform, was approved through a series of state plan amendments (SPAs) allowing Idaho greater flexibility in benefit design, cost-sharing, and innovative initiatives designed to coordinate care, promote healthy behaviors and manage chronic diseases. Because it was one of the first states to take advantage of the DRA provisions to redesign Medicaid, Idaho's experience may be useful to other states looking to introduce similar policy changes into their Medicaid programs, although it is not clear the extent to which the Centers for Medicare and Medicaid Services (CMS) under the current administration will encourage the use of the DRA as a vehicle for state health care reform.

The proposed changes included restructuring eligibility categories so that they were based around health needs; developing specific goals related to process, quality, and outcomes for each group based on their health needs; tailoring benefits to the needs of each group, with a focus on prevention for healthy children; using management tools to improve the functioning of the delivery system; and developing and tracking quality measures over time. The goals of the policy changes that were aimed at low-income children and families were to bolster the employer-sponsored insurance system and to promote wellness by focusing on prevention and encouraging healthy choices by enrollees.

Between late April and early May 2006, Idaho submitted 13 State Plan Amendments, two Title XXI Amendments, and two 1115 Waiver Amendments to CMS, the federal agency responsible for administering the Medicaid program. The approved major changes affecting low-income children and families were implemented beginning in July 2006 and include:

- Benchmark benefit packages, which separated enrollees into Basic and Enhanced Plans based on their health needs and created an opt-in coordinated benefit plan for enrollees dually eligible for Medicare and Medicaid;
- Preventive health assistance (PHA) benefits consisting of Wellness benefits, which allow parents who keep their children up-to-date on well-child visits and immunizations to earn points that can be used to offset premium payments, and Behavioral PHA benefits, which provide vouchers that can be used for smoking cessation programs including counseling and pharmacotherapy and/or weight management services to beneficiaries who qualify;
- Pay-for-performance disease management programs, which reward providers at participating community health centers and Idaho's two family practice residency programs for identifying diabetic patients and administering recommended procedures for management of the disease;
- Eligibility changes for children in Medicaid and the Children's Health Insurance Program (CHIP) and new copayments for CHIP for use of the emergency room or emergency transportation in non-emergency situations;
- Expedited enrollment in Healthy Connections, the primary care case management program, which seeks to operationalize a medical home model and reduce costly, unnecessary emergency room use;
- An expanded premium assistance option that relaxes restrictions on dependent coverage contributions that make an employee plan eligible for premium assistance;
- Participation in a multi-state pharmacy purchasing pool that allows stronger negotiation on drug rebates; and
- The Healthy Schools Initiative, which seeks to improve preventive care guidance provided at public schools.

In addition, the state made a number of other changes that did not require submission of a SPA. These changes include outsourcing dental benefits for Basic Plan enrollees to a managed care organization (DentaQuest) that specializes in managing dental benefits, new premiums for children in families with incomes between 134-150 percent of the federal poverty level (FPL); and reimbursement increases for well-child visits. It is not possible to draw definitive conclusions about the effects of Idaho's Medicaid policy changes but a number of findings have emerged four years into implementation.

While Idaho succeeded in meeting many of the original goals of its policy changes, progress toward other goals has been limited. Successes include:

- A shift in Medicaid's focus toward prevention, through reimbursement increases for preventive visits, the addition of an adult wellness visit to the benefit package, and the implementation of Preventive Health Assistance benefits;
- Increased emphasis on Medicaid quality improvement, through the introduction of the pay-for-performance diabetes disease management program;
- Advances in developing a medical home model for Medicaid, through streamlining Healthy Connections enrollment and a new initiative being launched by the Idaho Primary Care Association;
- Improvements in the delivery of dental care as a result of the outsourcing of dental coverage for Basic Plan enrollees and resulting increase in access to dental care. Based on the success demonstrated with improved access and service utilization, Idaho is now in the process of expanding this program to the participants on the Enhanced Benefit Plan;
- Cost savings in its pharmacy program as a result of joining a multi-state pharmacy purchasing pool; and
- Perceived improvements in transparency, discussion, and collaboration between Medicaid, state legislators, and provider and consumer groups.

The political, regulatory, and institutional environment in Idaho that facilitated these successes includes:

- Early support of the state's legislature, which also helped the initiatives maintain momentum through a change in leadership in the governor's office and in the Division of Medicaid;
- Recent investments in electronic health records, such as the Idaho Health Data Exchange, that will likely enable further development of disease management initiatives;
- Collaboration and support from federally qualified health centers (FQHCs) and medical residencies in the design and implementation of the diabetes disease management program;
- A provider network under the Healthy Connections primary care case management program that facilitated communication to providers and beneficiaries about the policy changes; and
- CMS support for using the DRA as a vehicle for policy changes.

Despite these successes, a number of barriers led to implementation delays or tempered the impact of some of the policy changes. These include:

- The lack of off-the-shelf, working examples of how to design and implement disease management programs and personal health benefits in Medicaid;
- Challenges associated with influencing beneficiaries' health behaviors;
- Lack of coordination between the personal health benefits, the pay-for-performance disease management program, and prior disease management efforts in the state;
- Difficulty collecting accurate, complete data on care being provided to diabetic patients and lack of feedback to primary care physicians in the Healthy Connections program on the service patterns of their Medicaid clientele;
- Low take-up in the premium assistance programs;
- Issues related to regulatory oversight of mental health service provision and limited access to appropriate/comprehensive substance abuse and mental health treatment in Medicaid; and
- Budget holdbacks as a result of the economic recession.

In general, key informants in the state did not perceive that the implemented changes targeting children and non-disabled adults addressed the root sources of cost and quality problems in Medicaid and therefore did not expect the policy changes to lead to noticeable changes in these areas. Nevertheless, there was a perception that access to and use of services improved for some groups. Additional policy changes will be needed in Idaho's Medicaid program to achieve the goals it set out to achieve related to better coordination and management of care and promoting healthy behaviors among its enrollees. Future Medicaid initiatives will likely be heavily dependent on how the state weathers the current economic downturn and on the policy changes associated with federal efforts to reform the health care system.

Medicaid Policy Changes in Idaho under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges

INTRODUCTION

In 2006, Idaho became one of the first states in the nation to implement changes to its Medicaid program under authority granted by the 2005 Deficit Reduction Act (DRA) (PL 109-171). The Deficit Reduction Act of 2005, signed into law in February 2006, gave states new flexibility in the design of their Medicaid programs, including allowing states to tailor benefit packages to different categories of enrollees, expand options for premium assistance for private health insurance, and increase flexibility in designing new systems for long term care coordination (Centers for Medicare and Medicaid Services "The Deficit Reduction Act.").

In particular, the DRA provided states with a new vehicle for making changes to their programs, allowing the use of a state plan amendment (SPA) for policy changes that previously would have required a waiver. The ability to bypass a waiver using a SPA allows for policy changes that are not budget neutral and that do not need to be renewed (Rudowitz and Schneider 2006). The DRA also relaxed two requirements that previously governed Medicaid programs, statewideness and comparability (Health Management Associates 2007). Statewideness refers to the availability of all Medicaid services and programs in all areas of a state; comparability refers to the availability of all Medicaid services and programs to all eligibility groups. Relaxing these two standards allows states to implement pilot programs in only one part of the state and to tailor benefit packages to the needs of different eligibility groups (Health Management Associates 2007).

Two key provisions of the DRA relate to changes in benefits and cost-sharing for enrollees. The DRA allows states to create benchmark benefit packages that offer different benefits to different categories of enrollees. Similar to states' options when designing benefit packages in the Children's Health Insurance Program (CHIP), the benchmark benefits can be the Blue Cross/Blue Shield option under the Federal Employee Health Benefits Plan, the plan offered to state employees, the plan offered by the largest health management organization in the state, secretary-approved coverage, or "benchmark equivalent" coverage, which must have the same actuarial value as one of the options listed above.

Benchmark benefit packages must be voluntary for certain groups of enrollees, including pregnant women with income less than 133 percent of the federal poverty level (FPL), the blind or disabled, those dually eligible for Medicaid and Medicare, terminally ill hospice care recipients, foster/adoption assistance children, long term care recipients, and women who are eligible for breast and cervical cancer programs. In addition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits must continue to be offered to all children under age 19 enrolled in Medicaid (Health Management Associates 2007).

The new cost-sharing rules in the DRA apply only to enrollees with income above the FPL. Those with income between 100 percent and 150 percent of the FPL may be charged up to 10 percent of the cost of the service they receive, and those with income above 150 percent of the FPL may be charged up to 20 percent of the cost of the service. However, cost-sharing remains prohibited for emergency services, family planning services and supplies, preventive care services for children under age 18, and all services provided to certain groups (e.g., children under age 18 in mandatory eligibility categories, pregnant women, etc.). For those beneficiaries who face cost-sharing requirements, total out-of-pocket spending may not exceed 5 percent of family income. An important change in the DRA is that states are allowed to make cost-sharing enforceable, that is, the state may terminate coverage or the provider may deny services for failure to pay (Health Management Associates 2007).

Concerns about Medicaid spending growth led to a desire to reform the operation of Idaho's Medicaid program to make it sustainable for future generations and to encourage the greater use of preventive care and the adoption of healthier lifestyles. The policy initiative, known as Modernizing Medicaid: Value-Based Reform, was approved through a series of state plan amendments (SPAs) allowing Idaho greater flexibility in benefit design, cost-sharing, and innovative initiatives designed to coordinate care, promote healthy behavior and manage chronic diseases.

Because it was one of the first states to take advantage of the DRA provisions to redesign Medicaid to function

more like commercial insurance and focus on prevention and wellness, an analysis of Idaho's experience could be useful to other states looking to introduce similar policy changes into their Medicaid programs, although it is not clear the extent to which the Centers for Medicare and Medicaid Services (CMS) under the current administration will encourage the use of the DRA as a vehicle for state health care reform.

This report describes Idaho's process of adopting and implementing the Medicaid policy changes approved under the DRA. The information contained in the report derives from interviews with state officials, advocates, and providers, documents available from the state's website, and external reports and analyses of the state's experience with the policy changes. Unless otherwise cited, findings in this paper are based on the key informant interviews. The focus of this report and of the project more broadly is on the policy changes that were introduced that affected children and non-elderly adults.[1] Policy questions related to individuals dually eligible for Medicaid and Medicare and long-term care were outside the scope of this study. Subsequent reports will examine service use patterns have been changing over time and, where possible, will assess the impacts of particular Medicaid policy changes that were made.

BACKGROUND

Idaho is one of the least populated states in the nation with just under 1.5 million residents and the 7th lowest population density in the country (U.S. Census Bureau 2009). While Idaho has one of the nation's lowest poverty rates, the share of its population with low-incomes (i.e. less than 200 percent of the FPL) is 34.8 percent, which is higher than average (Current Population Survey 2006-2007). Idaho's ranking varies across different health indicators—the state is in the lower half of states on overall mortality and on mortality rates due to cancer, diabetes, and heart disease, but its prevalence of adult asthma (8.7 percent) and poor mental health status (34.6 percent) are both slightly above the U.S. average (National Center for Health Statistics 2008; Behavioral Risk Factor Surveillance System 2007).

In contrast, Idaho consistently ranks below other states when it comes to access to care, ranking lowest in the nation in the share of children who had both a preventive medical and dental visit in the past year (46 percent); it ranked 39th in the share of adults who visited a dentist or clinic in the past year (66.9 percent), and 25th in the share of children who received needed mental health care or counseling during the past year (63.4 percent) (National Survey of Children's Health 2007; Behavioral Risk Factor Surveillance System 2007).

Eligibility for public coverage is more restrictive in Idaho than in most other states; for example, the state has no medically needy program under Medicaid, covers pregnant women at the federally-mandated minimum income level, and has very low eligibility for parents (Public Citizen 2007; Cohen Ross and Marks 2009). As in other states, eligibility for Medicaid and the Idaho Health Plan for Children (the state's CHIP) reflects a patchwork of eligibility categories.

Idaho covers infants and children through 5 years of age and pregnant women up to 133 percent of the FPL in its Medicaid program. Children ages 6 to18 years are covered up to 100 percent of poverty under Title XIX of the state's Medicaid program and between 101 and 133 percent of poverty under a Title XXI-funded Medicaid expansion program. Children ages 0-18 with income between 134 and 185 percent of the FPL are covered under a Title XXI-funded separate CHIP.

Medicaid coverage is also available for working parents up to 28 percent of the FPL and nonworking parents up to 22 percent of the FPL (Cohen Ross and Marks 2009). Idaho also covers a small number of parents and childless adults in a premium assistance program under an 1115 Waiver to its Title XXI CHIP program (Artiga and Mann 2007). This program, known as Access to Health Insurance, provides up to $100 of monthly premium assistance to employees of small businesses with income under 185 percent FPL (Artiga and Mann 2007; Idaho Department of Health and Welfare, "Health Insurance Premium Assistance" 2009).

Idaho also offers a premium assistance program to children, known as the Children's Access Card, with income between 134 and 185 percent of poverty and with access to insurance through their parents' employer (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009). Up to $100 per month is given for each child enrolled in their parents' employer plan, with a maximum monthly benefit of $300 per family (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009). The Access to Health Insurance Program began in 2005, and as of December 2007, 485 participants were enrolled in one of the two premium assistance programs, including 154 children, 238 parents/caretakers, and 93 childless adults (Idaho Department of Health and Welfare, "Medicaid Reform Status Report" 2007), which represents a

small share of children in this income range who receive publicly-funded coverage. Enrollment in CHIP for among children in the same income range was 14,000 in fiscal year 2007 (Centers for Medicare and Medicaid Services 2009).

Idaho's Medicaid program spent just under $1.3 billion in FY 2008 including both state and federal funds, to cover an average monthly enrollment of 185,000 (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009). An additional $44.8 million was spent on Title XXI-funded programs, including both a Medicaid expansion program and a separate Medicaid look-alike Children's Health Insurance Program in FY 2008 to cover a monthly enrollment of 19,352 in June 2007 (Smith et al. 2008). Idaho has a favorable federal matching rate—69.87 percent for its Medicaid spending and 78.91 percent for Title XXI Children's Health Insurance Program in FY 2008 (Assistant Secretary for Planning and Evaluation 2010).[2]

Idaho's Medicaid program and CHIP accounted for about 24 percent of the state's annual expenditures in fiscal year 2009, providing coverage for 15 percent of the state's population in fiscal year 2006 (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009; Medicaid Statistical Information System 2006). Medicaid spending grew at a rate of 12 percent between 2000 and 2004, which placed pressure on the state budget (Blewett et al. 2007).

In Idaho, nearly two-thirds (65 percent or 143,500) of Medicaid enrollees are children, and another 22,000 children are enrolled under Title XXI-funded programs (Centers for Medicare and Medicaid Services 2006; Medicaid Statistical Information System 2008).[3] Despite their large share of the Medicaid caseload, children account for just 21 percent of Medicaid expenditures ($221 million), (Medicaid Statistical Information System 2008).[4] Consistent with the patterns found in other states, Idaho's Medicaid spending is concentrated on the elderly and the disabled (Holahan et al. 2009a; Holahan et al. 2009b). The disabled population, which makes up 14 percent of enrollees, is the group with the highest expenditure share, constituting 49 percent of total Medicaid expenditures, or $520 million. The group with the next largest expenditure share is the elderly, making up 20 percent of expenditures, or $209 million, while accounting for only 6 percent of Medicaid enrollment. Other adults, including parents and pregnant women, make up 15 percent of enrollees and just 10 percent of spending, or $107 million (Medicaid Statistical Information System 2008).[5]

Idaho is one of the few Medicaid programs that does not fully capitate any of its enrollee groups. Idaho's Medicaid program has a primary care case management (PCCM) program called Healthy Connections. Primary care providers receive a monthly fee of $3.50 for each enrollee who is assigned to them, and enrollees need to obtain referrals from their primary care provider for certain specialty services. Idaho has 38 hospitals across the state—21 public hospitals, 14 non-profit, and 3 for-profit (American Hospital Association 2009)—and 10 Federally Qualified Health Centers (FQHCs) providing services in 63 clinic sites (National Association of Community Health Centers 2008). The state also has approximately 3,200 physicians, 1,200 dentists, and 9,600 registered nurses (American Medical Association 2008; American Dental Association 2008; Bureau of Labor Statistics 2007).

In 2005, Idaho had been planning to seek a waiver from the CMS to make changes to its Medicaid program (Russell 2005; Rogers 2006). However, once the DRA was signed into law in February 2006 (PL 109-171), the state opted, with strong encouragement from CMS, to propose a series of state plan amendments (SPAs) in place of the waiver. In 2006 and 2007, seven states (Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, and West Virginia) received CMS approval of SPAs taking advantage of the new flexibility the DRA offered (Families USA 2009). Idaho was the third state to take advantage of these new provisions, proposing new benefit packages, cost-sharing, and efforts aimed at prevention and care coordination, including targeted disease management and personal health benefits (Russell 2005; Smith et al. 2006).

IDAHO'S PROPOSED MEDICAID POLICY CHANGES

In 2005, then Governor Dirk Kempthorne led an effort to "modernize" Idaho's Medicaid program (Kempthorne 2005; Kempthorne 2006). The effort to introduce fundamental changes to Idaho's Medicaid program grew out of stated concerns related to the growing costs of the program and the potential adverse impacts on state priorities outside of health, the lack of sufficient attention paid to outcomes, and the perceived mismatch between eligibility categories and benefits packages. One particular area of concern was the mental health system, which was perceived to have too little provider oversight and to be insufficiently targeted to beneficiaries with high mental health care needs.

Idaho's proposed Medicaid policy changes aimed, on a broad level, to maintain a holistic perspective (by encouraging improvements in—or at least not causing harm to—non-Medicaid parts of the state's health care system); to promote greater simplicity and fairness in the Medicaid program; and to create value in the program—by for example, striving for high quality care and improved health outcomes for Medicaid enrollees. State officials explained that the policy changes were not intended to drastically reduce program costs; rather, the focus was on reforming the management and operation of Medicaid so it would be sustainable, efficient, and a leading force for prevention-centered care in the state.

To accomplish the above goals, the state proposed restructuring eligibility categories to be based around health needs; developing specific goals related to process, quality, and outcomes for each eligibility group based on their health needs; tailoring benefits to the needs of each group, with a focus on prevention for healthy children; using management tools to improve the functioning of the delivery system; and developing and tracking quality measures over time (Kempthorne 2005). Policy changes that targeted low-income children and families focused on bolstering the employer-sponsored insurance system and promoting wellness by focusing on prevention and encouraging healthy choices by enrollees.

The early plans included the creation of three separate eligibility groups: (1) low-income children and working-age adults who are not disabled, (2) individuals with disabilities or special health needs, and (3) elders. Separate goals, benefit packages, and performance measures were defined for each group. Other proposed changes included managed care contracting for durable medical equipment; pay-for-performance initiatives aimed at offering greater incentives for preventive care; reliance on disease management for different chronic health problems such as diabetes, depression, hypertension, asthma, and hyperlipidemia; and expanding the use of a number of technologies, including electronic health records, disease registries, and others with the goal of improving the Medicaid service delivery system and preventing and managing chronic diseases among beneficiaries.

The plan was developed by the Governor and his staff. As part of this process, Medical Assistance rules were rewritten to reflect the benchmarks, public hearings were conducted, written comments received, and the rules were submitted to legislative review. State officials held a public forum in each of the state's seven regions in January 2006; created a web site for public input, which received over 100 posted comments; collaborated with the state's universities to host meetings with program experts and key stakeholders to discuss policy ideas; and received comments from the Medical Care Advisory Committee on the policy change statutes. While the public forums were generally well-received and the Department concluded that there was public support for the guiding principles of Medicaid Modernization, one organization raised concerns about the short notice given in advance of the forums, the fact that they were scheduled during work hours and that some attendees felt that their questions were not addressed (Idaho Community Action Network 2006; Idaho Department of Health and Welfare "Public Invited…" 2005).

CHANGES APPROVED BY CMS

The process of gaining approval from both the state legislature and CMS was accomplished quickly. The Governor submitted a concept paper to CMS in October 2005, and in February and March 2006 the state legislature passed and the Governor signed the Idaho Medicaid Simplification Act and companion bills that would provide the legislative authority for the policy changes (Rogers 2006; Idaho Department of Health and Welfare "Federal Approval…" 2006).

Despite past difficulty getting legislative approval to expand Medicaid in Idaho, the state legislature was supportive of these Medicaid policy changes and of the goal of increasing personal responsibility for health behaviors. A dozen separate bills were passed by the state legislature in 2006, which solidified state support for the policy changes and allowed them to move forward even as Governor Kemphorne, the architect of the initiative, stepped down from his post in the summer of 2006 and a new administration took office.

Between late-April and early-May 2006, Idaho submitted 13 State Plan Amendments, two Title XXI Amendments, and two 1115 Waiver Amendments to CMS as part of Idaho's Medicaid Modernization effort. The approved changes include:

1. Benchmark benefit packages
2. New copayments for CHIP
3. Preventive health assistance (PHA) benefits
4. Pay-for-performance disease management programs

5. CHIP eligibility changes
6. New premiums for CHIP
7. Expedited enrollment in Healthy Connections, the PCCM program
8. Expanded premium assistance option
9. Participation in a multi-state pharmacy purchasing pool
10. Healthy Schools Initiative
11. Non-emergency transportation brokerage

Each of these changes is explained in greater detail below.

Benchmark Benefit Packages

The state created three benchmark benefit packages that were tailored to the needs of different categories of enrollees (see table 1). Health risk assessments for all enrollees were proposed to be used to place enrollees into the appropriate benefit package upon enrollment in Medicaid (SPA 06-002). The first two plans to be approved, the Basic and Enhanced Plans, were approved by CMS on May 25, 2006. The Medicare/Medicaid Coordinated plan was submitted in April 2007 and approved in February 2008. The benefit packages in Medicaid and the separate CHIP program were replaced by the Basic and Enhanced Plans, streamlining benefits for children across income groups. Prior to the policy changes, the separate CHIP benefit package had more limited benefits than Medicaid for some types of services, one notable example being that dental coverage was only provided for emergency services.

The *Basic Benchmark Plan* is a basic benefit package designed for non-disabled children and working-age adults that includes standard federally-mandated benefits, inpatient hospital services, outpatient and professional services, prescription drugs, preventive dental, mental health counseling, and vision services, which were available to these individuals before introduction of the new benefit packages; that adds new preventive health assistance benefits (described below), nutrition counseling, and adult wellness benefits; but that excludes long term care services and targeted case management that had been available before introduction of the new benefit packages. This plan also includes service limits for some mental health services and therapies, which can be overridden through a prior authorization process.

The *Enhanced Benchmark Plan* includes all the benefits of the basic plan, plus more generous coverage of mental health and inpatient services. This plan is designed for beneficiaries with disabilities and special health care needs, and includes coverage for intermediate care facilities and nursing facilities (SPA 06-003). Intensive mental health benefits are also available to enrollees in this plan, including individual, group, and family psychotherapy, psychosocial rehabilitation, community crisis support, and mental health case management, and unlimited inpatient mental health services.

The *Medicare/Medicaid Coordinated Benchmark Plan* is designed for beneficiaries enrolled in both Medicare and Medicaid and allows beneficiaries to receive all needed services, including those covered by Medicaid, through their Medicare Advantage Plan. Two Medicare Advantage Plans in the state have contracted with Medicaid to provide care coordination. Medicare-eligible individuals must be enrolled in Medicare in order to enroll in Medicaid, but they are not required to be enrolled in a Medicare Advantage plan (SPA 06-012, SPA 06-013).

A fourth plan, known as the ***Standard Benefit Plan***, covers only federally-mandated benefits and was created because CMS required that beneficiaries be able to refuse to enroll in one of the three benchmark plans described above. The Standard Benefit Plan is available to such beneficiaries but is very limited in what benefits it covers and excludes dental and prescription drug coverage.

New Copayments for CHIP

CMS approved an amendment to both Idaho's Medical Assistance State Plan and Children's Health Insurance Program that allows the state to begin charging a $3 copayment for Medicaid and CHIP participants who use the emergency room or emergency transportation for non-emergency situations.

Preventive Health Assistance Benefits

CMS approved three types of Preventive Health Assistance (PHA) benefits that reward positive health behaviors and encourage prevention: Wellness benefits were approved for children in families with income between 134 to 185 percent of the FPL, who are also required to pay monthly premiums. Parents earn points every quarter that their children are up-to-date on well check-ups and immunizations. These points exactly offset the $10

monthly premium for children with incomes between 134-149 percent FPL when they are credited to the parent's account and offset two-thirds of the $15 monthly premium for children with incomes between 150-185 percent of the FPL, so parents have the opportunity to reduce or eliminate the required premium payments as long as they keep their child up-to-date. This benefit was approved through an amendment to the state's Children's Health Insurance Program (Idaho Title XXI State Plan 2007).

The Tobacco Cessation and Weight Management benefits were approved as part of the new benefit packages (SPA 06-002, SPA 06-003, SPA 06-012). In general, Idaho Medicaid does not cover tobacco cessation aids, but the new Tobacco Cessation benefit covers the use of Food and Drug Administration-approved nicotine replacement therapies, such as Chantix or Wellbutrin. Enrollees who have expressed interest in quitting smoking and are enrolled in an approved cessation program can receive up to $200 in assistance toward the cost of these therapies. Similarly, the Weight Management benefits provide vouchers of up to $200 per year to participants who are underweight (body mass index (BMI) of less than 18.5) or obese (BMI of 30 or greater) to help pay for weight management programs.

Pay for Performance/Disease Management

Together with the Idaho Primary Care Association and two medical residency programs, Idaho Medicaid designed a pay-for-performance program for the management of four diseases—diabetes, hypertension, depression, and asthma. These diseases were chosen in part because clinical best-practice standards had already been developed for them in the literature. The state submitted a SPA to CMS in November 2006 that was approved in June 2007, and was granted approval to use enhanced primary care case management (PCCM) fees to reward Healthy Connections providers who adhere to clinical best practices for diabetes care management for their patients enrolled in the Basic and Enhanced benchmark plans. In November 2007 the state decided not to pursue the other three programs and to focus exclusively on diabetes.

CHIP Eligibility Changes

Idaho restructured eligibility thresholds for their Medicaid and CHIP programs for children through a Medicaid SPA (06-014) and a CHIP SPA (Idaho Title XXI State Plan 2007) approved in May 2006. The change shifted enrollment of children from birth to age 18 with family incomes between 134-149 percent of poverty from the Medicaid expansion program to the separate CHIP program. The state maintained the Medicaid expansion program for children ages 6 to 18 with income between 101-133 percent of the FPL. Children with family incomes between 150-185 percent of the FPL remained covered under the separate CHIP program. This amendment also lifted the asset test requirement for all children under 185 percent of the federal poverty-level.

New Premiums for CHIP

Switching some children from the Medicaid expansion to the separate CHIP allowed Idaho to begin charging $10 monthly premiums to children with incomes between 134 and 149 percent of the FPL in CHIP. Child enrollees with family incomes between 150-185 percent of the FPL continued to pay a $15 monthly premium ($10 for medical services and $5 for dental services). Premium payments only apply to children enrolled in the Basic Benefit Package; enrollees with the Enhanced Benefit Package are exempt from premiums.

Expedited Enrollment in the PCCM Program

Healthy Connections, the state's PCCM program that was authorized through a waiver prior to Idaho's broader policy changes, was merged into the benefit plans, and most enrollees in the basic and enhanced benchmark benefit packages are required to enroll with a Healthy Connections provider at the time of enrollment (SPA 06-002, SPA 06-003). This program operates in all counties in the state and is mandatory in counties that have at least two Health Connections providers. Enrollees may choose a different Healthy Connections provider for each member of their family enrolled in Medicaid and may change their provider on the first of the following month upon request. Those who do not choose a provider are assigned to one in their area.

Expanded Premium Assistance Option

In an effort to raise enrollment in premium assistance programs, the state gained federal approval through an 1115 Waiver Amendment submitted in May 2006 to drop the requirement that employers contribute 50 percent of the cost of dependent coverage. Qualifying employees, their spouses, and children must have family income no greater than 185 percent FPL to be eligible for the premium assistance programs (the Children's Access Card for children and Access to Health Insurance for adults employed in small businesses).

Multi-state Pharmacy Purchasing Pool

Being a small state, Idaho had historically had trouble negotiating with pharmaceutical companies for supple-

mental rebates on purchases of prescription drugs (Warn 2005). In 2006, Idaho was granted federal approval to join TOP$, a multi-state drug purchasing pool, increasing the state's leverage to negotiate these rebates (SPA 06-007).

Healthy Schools Initiative

The Healthy Schools Initiative was approved by CMS in a SPA and added to the state's children's health insurance program in May 2006 (Idaho Title XXI State Plan 2007). The approved changes allow the state to implement school-based prevention services for low-income children using funds appropriated under the 10 percent administrative cap in CHIP. The state planned to use the funds to hire registered nurses to work in schools to provide health counseling and education, screenings, prevention services, health coordination, and referrals, as well as provide application assistance for Medicaid and CHIP.

Non-Emergency Transportation Brokerage

Idaho was authorized to contract with a non-emergency medical transportation broker to transport Medicaid beneficiaries who need to access health care but have no other means of transportation (SPA 06-009).[6]

IMPLEMENTATION OF POLICY CHANGES

Benefit and Cost-Sharing Changes

Implementation of the new benchmark benefit packages began in July 2006 for the Basic and Enhanced Plans. The Department of Health and Welfare sent letters to current enrollees in June 2006 explaining the changes and briefly outlining the differences between the benefit packages. However, according to providers and safety net organizations interviewed for this study, the implementation of the new benefit packages was not highly visible to all providers since it did not have a large impact on the way they provided services to their patients.

By July 2007, 104,450 participants were enrolled in the Basic Plan and 33,617 were enrolled in the Enhanced Plan (Idaho Department of Health and Welfare "Medicaid Status Report Update" 2007). Children make up nearly 90 percent of Basic Plan enrollees (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009).

New enrollees were immediately placed into a plan and current enrollees were phased into the new plans at their regularly scheduled renewal. The default plan for both child and adult enrollees is the Basic Plan; participants are placed into the Enhanced Plan if they meet one of the triggers established by the Department of Health and Welfare (waiver participants, individuals that are developmentally disabled, individuals with serious emotional disturbance or serious and persistent mental illness, organ transplant participants, etc.) or if they are determined to have special physical or mental health needs through a health risk assessment.

It is the role of the primary care provider (PCP) to refer a patient to a mental health or other specialist to conduct a comprehensive health risk assessment to determine whether the patient's needs warrant enrollment in the enhanced plan. Upon completing the comprehensive assessment, the provider must submit a form to the Department of Health and Welfare indicating that the patient meets the requirements of enrollment into the Enhanced Plan and flagging the Enhanced services that the patient needs (additional psychotherapy, service coordination, partial care, developmental disabilities, psychosocial rehabilitation, and/or inpatient psychiatric hospitalization).

The results of the health risk assessment trigger an administrative switch from the Basic to the Enhanced Plan. This switch can take place as soon as the results of the assessment are sent to Medicaid; enrollees do not need to wait for their renewal date to switch plans. At the time of annual renewal, the Department of Health and Welfare also conducts a review of participants' utilization of mental health services during the prior year and will recommend the participant for a comprehensive assessment if the utilization patterns indicate that the participant could benefit from having the additional services provided by the Enhanced Plan (Clement 2006).

The adult wellness exams became available to enrollees as they were phased into the new benchmark plans. The state estimates that in state fiscal year 2007, 10 percent of adult participants received a wellness exam (Idaho Department of Health and Welfare "Medicaid Status Report Update" 2007). In July 2006, Medicaid participants were sent a mailing explaining the new wellness benefits, which include the new adult wellness checks, benefits to help participants quit smoking and lose weight, and some cancer screenings covered by the benchmark benefit plans.[7]

The new Preventive Health Assistance (PHA) benefits were implemented in January 2007 for children with family income between 134-185 percent of the FPL. From January to September, the state began rewarding parents who kept their children up-to-date on well-child checks and immunizations by paying for delinquent

premiums for children whose accounts were at least two months in arrears. Remaining benefits could then be accessed in the form of vouchers to purchase car seats, bicycle helmets, and/or sports equipment. However, CMS objected to giving rewards that were not specific to children's medical needs, and in September 2007, nine months after the benefits were first implemented, the state began using the wellness points exclusively to offset both delinquent and current premiums.

While the intent of the premiums was to increase participant responsibility for paying for medical benefits, allowing the points to offset premiums provided another option to families who had difficulty paying the premiums. Parents who must pay premiums for their children's coverage received a letter informing them of the premium amount and the PHA benefit. Parents are also notified in writing when Medicaid records do not confirm that their children's recommended check-ups or immunizations are current, which would disqualify them for the benefits for that quarter. If the children are current on immunizations and check-ups, parents are encouraged to contact state staff, who will then work with the parents to establish an alternate form of verification.

Data provided by Idaho Medicaid officials indicate that only about 100 children lost coverage in 2008 due to failure to pay premiums and that the share of child enrollees who have lost coverage due to failure to pay premiums dropped from 15-20 percent before introduction of the PHA benefits to 4 percent in 2008 and less than 1 percent in 2009.

Information on these new benefits was included in a monthly newsletter sent to Medicaid providers called Medic/Aide. The December 2008 issue (Medic/Aide 2008) of the newsletter included an overview of the PHA program and telephone numbers to call for additional information. Additional efforts to educate providers included an article in the American Academy of Pediatrics state newsletter, information flyers enclosed with Healthy Connections roster mailings to each clinic, and presentations at numerous annual provider healthcare conferences across the state and to medical associations. Providers were also encouraged to use appropriate diagnosis and CPT codes when billing for well-child visits to ensure that patients received credit for staying up-to-date. However, it appears that not all providers are aware of this benefit. By February 2010, over 20,000 children had earned points for staying up-to-date on well-child checks and immunizations. These points have been used to pay $1.5 million in premiums.

Under the tobacco cessation and weight management benefits, posters and brochures are distributed to Healthy Connections providers, including Federally Qualified Health Centers (FQHCs) during regular Healthy Connections field staff visits. Program information has also been shared by presentations and participation in events with other stakeholder groups, including Head Start, the Association of School District Superintendents, the Division of Health, local health districts and community health fairs.

At the time of initial Medicaid eligibility determination and annually thereafter beneficiaries are sent a short health questionnaire asking them to fill out the height and weight of family members at least 5 years old who are "interested in improving their health by losing or gaining weight." The questionnaire also asks if each person listed wants "to stop smoking or using tobacco products" or wants "to manage their weight." The letter also states that participants must have a BMI in the obese or underweight range in order to participate in the weight management program and explains that a person may only participate in one of these programs at a time. Participants may earn up to $200 worth of points per year, which can be exchanged for vouchers to pay for "fitness and weight management program fees and tobacco cessation products."

In addition to Medicaid-initiated contact, outreach to the providers of these newly covered services often originates with client interest, i.e., beneficiaries suggesting programs or facilities they would be interested in using. Medicaid recruits these providers by emphasizing the potential for Medicaid enrollees to participate given their expressed interest in wanting to use these products/services. The voucher itself serves as the provider agreement. To date, the approved services and products are FDA-approved nicotine replacement gums, patches, and lozenges, nose spray, inhalers, buproprion, Chantix and Wellbutrin (Idaho Department of Health and Welfare, "Smoking Cessation Products" 2007), Weight Watchers programs, and a number of fitness centers and gyms offering a specific weight management program, fitness classes, and diet and nutrition education (Idaho Department of Health and Welfare, "Approved Vendor Lists for Eastern, Northern, and Western Idaho" 2007).

Medicaid beneficiaries who attempt to get smoking cessation aids at a pharmacy but are denied[8] and participants who are identified through the Medicaid Management Information System (MMIS) as having diabetes are also sent information on the PHA benefits. Interested participants who return the health questionnaire and

qualify for the programs are sent a list of participating local providers in their area of the state. Once they arrange for services they are enrolled in the program.

Beneficiaries must reapply for the programs each year and meet all qualifications, including continuing to have a BMI of less than 18.5 or 30 or greater (as calculated from the beneficiary's self-reported height and weight on the questionnaire) for weight management benefits, in order to continue participating. According to state health officials, the rationale behind the PHA benefits is to assist people in developing healthy habits when they are ready and willing to make a behavioral change, as expressed through their completion of the health questionnaire and arranging for services. In 2009 there were 1,061 adult and child participants in the weight management program and 361 adult and child participants in the tobacco cessation program. Preliminary results from a small survey of PHA participants indicate that some participants have been successful at managing their weight through diet and exercise and at quitting smoking. However, a full course of therapy for tobacco cessation is typically 12 weeks, while the PHA benefit funds only about 7 weeks, depending on the pharmacy price. This has caused some participants to return to smoking when the PHA benefit expires.

While the PHA benefits are aimed at changing beneficiary behavior, the pay-for-performance program had the goal of improving provider performance in the area of chronic disease management. The state had initially planned to offer programs for several conditions, including diabetes, asthma, depression, and hypertension, but has only moved forward on the diabetes program. The state faced difficulty getting regional CMS review and acceptance of the amendment to the Healthy Connections provider agreement. However, there has been CMS approval of the State Plan Amendment that has allowed this program to move forward with federal matching funds.

Diabetes was the condition chosen for the pilot program because of its high prevalence and high number of comorbidities, including depression, cardiovascular disease, and obesity. The pilot program began in three locations in July 2006: a FQHC in Nampa, a family medicine residency in Boise that is a FQHC look-alike, and a family medicine residency in Pocatello, and expanded statewide to all FQHCs except Glenns Ferry and Idaho Falls in the fall of 2007.

The state hopes to expand the program to individual providers within a few years. The program rewards providers for identifying and treating their diabetic patients on a registry by giving them a $50 payment for each diabetic patient they diagnose (and $10 for each year that they continue to see that patient), and a $10 payment for each of the following tests/procedures they give to a diabetic patient: A1C, influenza vaccine, blood pressure, lipid profile, urine microalbumin, foot inspection, foot microfilament test, funduscopic (eye) exam, depression screening, smoking behavior monitoring, weight management behavior monitoring.[9]

The state chose to begin by rewarding process measures to avoid punishing providers with different case mixes and to avoid incentivizing providers to enroll only their compliant patients, but some state officials and providers hope the program can evolve into one that rewards better outcomes. The payments are processed once a year and go to the health center/family residency, not directly to the providers. When the program began, the Medicaid Medical Director visited the pilot sites and had quarterly meetings with FQHC staff to promote the program. Data from the first quarter of 2008 indicate that in the first year of the pilot, the program reached 5 percent of diabetics in Medicaid, or 495 individuals, through providers who were participating in the program and spent $15,900 in enhanced provider payments (Center for Health Care Strategies 2008).

Pending the outcome of the diabetes program, the state has contemplated adding other conditions to the pay-for-performance model. However, CMS advised that each condition would need to be approved separately, which would slow the process of expanding the program.

The copayments for inappropriate use of the emergency room were implemented, but it appears that very few hospitals have been collecting them because the process for doing so under the DRA requires the hospital to refer the patient to another provider who would not charge them a copayment. Medicaid also allows providers to apply the same policies to their Medicaid patients as their other patients, so if the practice charges a fee for missed appointments, Medicaid allows them to charge that fee to their Medicaid patients as well. Data from December 2007 indicate that less than 150 participants were charged copayments for any reason (Idaho Department of Health and Welfare "Medicaid Status Report Update" 2007).

Enrollment Changes

As indicated above, the asset test for children was eliminated in Medicaid and CHIP, and in July 2006 children

with family income between 134-149 percent of FPL were switched from the Medicaid expansion program to the Children's Health Insurance Program (Idaho Title XXI Program Fact Sheet 2007). This was an administrative change that did not affect beneficiaries' access to services or provider networks since all children in both Medicaid and CHIP were placed into the new Basic and Enhanced benefit packages with the same fee-for-service, PCCM reimbursement system at about the same time. However, the change allowed the state to impose new premiums on children who were switched to CHIP, which were introduced in December 2006. The new premiums coincided with the introduction of the PHA wellness benefits.

In July 2006, Idaho began enrolling participants in Healthy Connections at the time of enrollment in Medicaid to speed up the time it takes for participants to be connected to a provider. Medicaid officials make two visits each year to every Healthy Connections provider to promote the use of Healthy Connections, to operationalize a medical home model and reduce costly, unnecessary emergency room use.

By December 2007, the median processing time to connect to a provider was 28 days from enrollment, down from 56 days before the change (Idaho Department of Health and Welfare, "Medicaid Reform Status Report" 2007). The share of enrollees with a primary care provider increased from 85 percent to 89 percent. Healthy Connections providers serve 150,000 Medicaid participants in over 400 sites in all of the state's counties (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009).

Following the relaxation of requirements on employer contributions, employer participation in Idaho's premium assistance programs more than doubled in the six month period spanning July to December 2007 but still remains low, at 118 (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). However, the number of children receiving health insurance through one of these programs remained steady over the same time period, and the number of adults participating in the program grew only modestly—31 more parents/caretakers, 7 more childless adults, and 6 fewer children were enrolled in December 2007 compared to July of the same year (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). The low enrollment seen in Idaho's premium assistance programs, which is consistent with the patterns found elsewhere in the country, could be due to the small number of uninsured low-income workers and families who have access to affordable employer-sponsored insurance (Kenney et al. 2009).

Financing and Reimbursement Changes

Motivated by a desire to curb cost growth, policy changes to the pharmacy purchasing system had begun in 2003 when Idaho joined Washington and Oregon in the Drug Effectiveness Review Project to evaluate the effectiveness of new drugs. In 2006, Idaho joined a multi-state drug purchasing pool known as The Optimal PDL Solution, or TOP$, with Delaware, Louisiana, Maryland, Pennsylvania, Wisconsin, and West Virginia. The larger market represented by the purchasing pool allows participating states to have greater negotiating power with pharmaceutical manufacturers.

The number of drug classes included in the supplemental review process increased from 11 under Idaho's single state program to 57 under the multi-state program (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). This program saves an estimated $10 million per year, and the savings generated are used in part to fund the PHA benefits, which cost about $1 million in fiscal year 2008.

The state has a preferred drug list and in 2004 launched a SmartPA℠ system for prior authorizations, which automatically checks the participants' medical and drug information against a preselected set of prior authorization (PA) criteria. If the drug request meets these criteria, the authorization will occur automatically. Only if additional information is required from the prescribing physician will a message indicate to the pharmacy that the physician must submit a PA form to the Medicaid office. The system allows many prescriptions requiring PA to be authorized and filled at the point of service, thus removing significant burdens on physicians to obtain PA (Medicaid Information Release 2004-04).

In July 2006, the state increased reimbursement for well-child checks by $12-20 per visit (an increase of 8-23 percent, depending on which procedure code is charged) in an effort to promote greater receipt of preventive care. This increase brought the Medicaid reimbursement rate for well-child checks up to the rate paid by commercial insurance.

Because of the desire to increase access to preventive dental care, the state chose to outsource the dental coverage for its non-disabled population (Basic Plan enrollees) to a managed care organization that specializes in managing dental benefits in September 2007. Without changing the budget for dental coverage, the state con-

tracted with Blue Cross—DentaQuest (formerly Doral Dental) to provide dental services under a new capitated program called Idaho Smiles. Participants received a one-page mailing in August 2007 introducing the new program (Idaho Department of Health and Welfare, "New Idaho Smiles Dental Program" 2007). DentaQuest increased provider fees an average of 7.7 percent for children's services and 3.9 percent for adults' services above the Medicaid rate when they began administering the program. Annually, the state assesses whether to increase the fee schedule, which DentaQuest passes on to providers. In 2008, rates were increased another 3.2 percent on average (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009). The number of private practice dentists that accept Medicaid patients increased by 22 percent since the program began, and enrollment in Idaho Smiles as of spring 2009 is 124,000 (Idaho Department of Health and Welfare, "Facts, Figures, Trends 2008-2009" 2009). While access may have improved for beneficiaries, the increased number of providers willing to accept Medicaid patients may have shifted clients away from FQHCs, as at least one FQHC reported a drop in their Medicaid patient rolls following the outsourcing.

The increase in access to and utilization of dental services among beneficiaries was higher than expected;[10] in the first year of the program, utilization rates were just over 50 percent, higher than DentaQuest has experienced in its operations in other states. The rapid increase in access and utilization has put financial pressure on DentaQuest since the per member per month rate that they had contracted with the state was based on lower historical access and utilization projections. In response to the increased utilization, DentaQuest has proposed some changes in benefit limits based on current acceptable dental standards, including limiting age ranges for which some procedures are covered, and decreasing the frequency of approved dental visits for adults.[11]

Healthy Schools Initiative

The Healthy Schools Initiative began in September 2006 and by July 2007 was active in 13 schools and reportedly provided over 17,000 health screenings and 934 referrals for vision, hearing, scoliosis, pediculosis, blood pressure, dental, and other services (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). CHIP applications were sent home with students and staff received education on students' chronic health problems (Department of Health and Welfare, "Medicaid Reform Status Report" 2007).[12]

DISCUSSION

While it is too soon to draw definitive conclusions about Idaho's Medicaid policy changes, a number of findings have emerged four years into implementation. To date, while Idaho succeeded in meeting some of the original goals of its policy change effort, progress toward other goals has been limited. Specific goals included increasing the emphasis on preventive care and wellness, increasing participants' ability to make good health choices, matching benefits with enrollee need, strengthening the employer-based insurance system, and developing and tracking quality measures. This section begins by reviewing some of the successes the state has achieved and then outlines the political, regulatory, and institutional environment that facilitated those successes. The section concludes with a discussion of the barriers the state faced that limited their progress toward achieving some goals.

Successes

Reimbursement increases for preventive visits, the addition of an adult wellness visit to the benefit package, and the implementation of Wellness PHA benefits have been potentially important steps in terms of shifting Medicaid's focus to prevention. The Behavioral PHA benefits offer a structure for supporting healthy behavioral changes on the part of Medicaid enrollees by providing financial support for managing weight or quitting smoking.

In addition, the introduction of the pay-for-performance diabetes disease management program was an important step in shifting the Medicaid program's focus toward quality improvement. It also established a process within Medicaid for rewarding performance that could be built upon and extended to other diseases or providers.

Advancements have been made in developing a medical home model for Medicaid, beginning with streamlining the Healthy Connections programs, which resulted in much quicker assignment of enrollees to a primary care provider. A new patient-centered medical home initiative that is being launched by the Idaho Primary Care Association will further the medical home model in 13 partner clinics operated by Idaho's FQHCs and residencies, seeking to improve care coordination between primary, specialty, and community services and to increase the use of electronic health records to enable easier identification of patients with unmet health needs and better management of chronic conditions (Idaho Primary Care Association 2009). The initiative, supported by a

grant from Qualis Health and the Commonwealth Fund, will extend the medical home model beyond Medicaid and may serve as a starting point for a statewide medical home model.

Another stated goal of the policy changes was to improve the functioning of the delivery system for dental care. The outsourcing of dental coverage for Basic Plan beneficiaries to a managed care system has reportedly smoothed the delivery of dental care and increased access at no extra cost to the state. Due to the program's success in increasing access to dental care, the state is exploring options to include Enhanced Plan participants in the contract as well. Idaho also experienced significant cost savings in its pharmacy program by joining a multi-state pharmacy purchasing pool.

In addition to the specific policy changes detailed above, the implementation of the Medicaid policy changes in Idaho may have had intangible but potentially important effects on the Medicaid program in the state and on perceptions of it. A number of stakeholders reported that the policy change effort had changed the culture and perception of the Medicaid agency—that the Medicaid program "feels different" and that it now offers greater transparency, friendliness, and open discussion. State legislators indicated that they feel more comfortable approaching the department. Monthly meetings between the Medicaid agency and key association groups (i.e., hospitals, medical associations etc.) were initiated to work through issues related to Medicaid policy changes and reportedly the process worked effectively, leaving little new on their agendas now.

Facilitators

An important factor in the success of Idaho's Medicaid policy changes was securing the early support of the state's legislature. In a few short months, the legislature passed a dozen bills, giving legislative authority for the state plan amendments to move forward. Legislative support also helped the policy changes maintain momentum through a change in leadership in the governor's office and in the Division of Medicaid.

Recent investments the state is making in electronic health records will likely enable further development of the disease management initiatives. In March 2006, the Idaho legislature passed House bill 738, establishing the creation of a Health Quality Planning Commission to plan and implement an electronic health data system in Idaho. In January 2008, the Idaho Health Data Exchange was launched as an independent, non-profit corporation (Idaho Health Data Exchange 2009). The program is still in the pilot phase, but is expected to go statewide within the next five years. New spending with funding from the federal economic stimulus package may also further the health information technology investment in the state.

Another important factor contributing to the successes of the Medicaid modernization effort was the collaboration and support the state received from the FQHCs and medical residencies, which worked closely with Medicaid to design and implement the diabetes disease management program. Medicaid also benefitted from having an existing provider network through its Healthy Connections program, which facilitated communication to providers and beneficiaries about the policy changes and will be important as the state continues to move toward a medical home model.

Finally, the role of CMS and the flexibility afforded by the DRA were extremely important to the state's ability to undertake these policy changes. While Idaho had originally planned to submit 1115 Waivers for these policy changes, the DRA provided a useful vehicle for Idaho's policy changes to move forward, and CMS was very responsive and encouraging of the state's initiatives under the DRA authority. However, the DRA regulations have yet to be finalized, so it is not known how the process will work for states seeking to undertake similar policy changes in the future.

Barriers

Idaho has encountered several barriers that have tempered the success of some of its policy changes. As one of the first states to embark on tailored benefit packages, personal health benefits, and disease management in their Medicaid program, Idaho lacked off-the-shelf, working examples of how to design and implement successful initiatives of this nature. As planned, Idaho did implement tailored benefit packages; however, it is not clear whether the new benefit packages had an impact on program costs or access to care.

In addition, Idaho, like programs around the country, continues to face the challenge of how to successfully influence positive changes in beneficiary health behaviors. The Behavioral PHA benefits have experienced low enrollment to date and are not structured in a way that can be expected to achieve widespread behavior change—for example, participants must be obese, not at risk of becoming obese, in order to qualify; the dollar value of the benefit is not high enough to support a full course of tobacco cessation products; and to this point, the PHA benefits have not been integrated into provider practices, either through the Healthy Connections pro-

gram or the pay for performance effort. However, a small survey conducted by the state indicates that at least some participants have found the benefits helpful in achieving their weight management and tobacco cessation goals. The state recently eliminated the maximum benefit in the program, which now allows participants to enroll in both programs concurrently. And while there are no plans to reduce benefits at this time, the current economic situation prevents the state from expanding the program.

The fact that few states have experience with personal health benefits in Medicaid means that little is known about how to structure them to maximize their impact; however, existing research has found little success with low-intensity or one-time rewards (Christianson 2007; Jepson et al. 2000; Kane et al. 2004; Redmond et al. 2007). In designing future initiatives, the state may wish to explore higher-intensity programs that may have greater success at changing enrollee behavior (Donatelle et al. 2004). Budgetary limitations may pose an obstacle to these initiatives, particularly in the start-up phase; however, more work will be needed to assess the potential cost-savings of higher-intensity programs in the medium- and long-term.

Likewise, the pay-for-performance program is likely to have only a limited impact on costs at this point in time, give its current reach (only eight FQHCs and two residencies are participating at this point), its scope (exclusive focus on diabetic patients) and the focus on the process of care as opposed to outcomes. As described above, Idaho's pay-for-performance program operates independently from its PHA program despite the fact that both seek to improve health outcomes by modifying the behaviors of providers and patients, respectively. However, despite the marketing of the PHA benefits toward patients and providers, some providers and FQHC staff remain unaware of the PHA benefits and their design, which represents a missed opportunity for providers to counsel patients on healthy behaviors and refer them to the PHA benefits.

In addition, the lack of coordination with prior disease management efforts in the state, such as the Diabetes Prevention and Control Program, represents another missed opportunity to actively build on networks of providers and standards that were already in place. While Idaho's pay for performance program is innovative in that it rewards providers for treating all diabetic patients (compliant and non-compliant), the lack of existing models at the national level for implementing these types of programs in Medicaid limits the ability of individual states to identify successful designs that can be implemented off the shelf.

A major implementation issue with the pay-for-performance program has been difficulties with the collection of accurate, complete data on care being provided to diabetic patients. In addition, while the Healthy Connections program is viewed as a way to reduce costly, unnecessary emergency room use, to this point, the state's attempt to provide feedback to PCPs on the service patterns of their Medicaid clientele, such as the extent of unnecessary emergency room use has not led to noticeable changes on emergency room use. Idaho may be able to concurrently expand the reach of its pay-for-performance program and introduce stronger management tools into its Healthy Connections program by integrating the two, but capacity to support the data needed to monitor performance may be limited in PCPs who do not practice at large facilities.

Idaho's demographics and geography also influence capacity in this regard, with many small practices located in rural areas. While recent state investments in electronic health records will improve providers' ability to collect this type of data, the plurality of data systems available and the high start-up costs, especially for small providers, makes adoption of a standard system difficult. New funding made available through the American Recovery and Reinvestment Act of 2009 will likely assist in this effort in the near future.

A barrier the state faced in strengthening the employer-based insurance system was the low take-up for its premium assistance programs. While premium assistance programs and Medicaid policy changes cannot be expected to address the underlying forces that have been eroding employer coverage (Reschovsky et al. 2006; Clemans-Cope and Garrett 2006), state officials hope that the premium assistance provisions that were included in the Children's Health Insurance Program Reauthorization Act of 2009 could increase enrollment in their program.

One of the principal motivations for Medicaid policy changes in Idaho was a desire to reform the mental health care system. While the targeted benefit packages give Medicaid the ability to keep a more watchful eye over the delivery of mental health services, other factors, such as a cultural preference for self-reliance, issues related to regulatory oversight of mental health service provision, and limited access to appropriate and comprehensive substance abuse and mental health treat-

ment also need to be addressed to achieve an efficient, effective mental health system.

The Medicaid program continues to work to establish minimum qualification criteria for individuals and organizations seeking to provide mental health services to the Medicaid population, but at the time of the interviews, many interviewees both inside and outside of Medicaid conveyed a sense of urgency in the need to improve the mental health care system and substance abuse treatment in the state. The Governor's Mental Health Transformation Work Group has been established to pursue the objective of an improved Mental Health/substance abuse health care system in the state. Additionally, Medicaid received federal approval through a State Plan Amendment to provide some substance abuse services for Medicaid participants.

Due to the effect of the economic recession on the state's finances, Idaho's Governor announced in 2008 that there would be a four percent holdback on 2009 general fund budgets and in September 2009 that there would be an additional four percent holdback on 2010 general fund budgets. For Medicaid, this translates into a $35.9 million cut in fiscal year 2009 alone, $10.4 million cut in state general funds in 2009 and the $25.5 million in funds that would have been received through the federal match. Medicaid plans to reduce spending by increasing service limits on some mental health benefits, reducing maximum benefits available for services provided by developmental disability agencies, reclassifying some antipsychotic drugs as preferred, reducing the fee schedule for incontinence supplies, reducing ambulatory surgical center reimbursements, and reducing personnel and operating costs within the Division of Medicaid (Idaho Department of Health and Welfare 2008).

Idaho's ambitious policy changes and rapid approval from both the state legislature and CMS enabled the state to effectively implement many of it policy changes within the original timetable. These policy changes have laid the groundwork for changing the way the Medicaid program delivers care. However, key informants in the state did not perceive that the implemented changes targeting children and non-disabled adults addressed the root sources of cost and quality problems in Medicaid and therefore did not expect the policy changes to lead to noticeable changes in these areas. Nevertheless, there was a perception that access to and use of services improved for some groups. Additional policy changes will be needed in Idaho's Medicaid program to achieve the goals of achieving better care coordination and management and of promoting healthy behaviors among its enrollees. Future Medicaid initiatives will depend in part on how the state weathers the current economic storm and on the policy changes associated with federal efforts to reform the health care system.

TABLE 1. COVERED SERVICES IN THE THREE BENCHMARK BENEFIT PLANS

SERVICES COVERED IN THE BASIC PLAN

- Inpatient Hospital Services
- Outpatient Hospital Services
  - Outpatient Occupational and Physical Therapy
  - Outpatient Psychotherapy
  - Outpatient Psychological, Speech, Hearing, PT, OT Evaluations & Diagnostic Services
  - Diabetic Education and Training Services
    - Group Counseling
    - Individual Counseling
- Emergency Hospital Services
- Ambulatory Surgical Center Services
- Physician Services (Medical and Surgical)
- Other Practitioner Services
  - Certified Pediatric or Family Nurse Practitioner
  - Physician Assistant
  - Chiropractor
  - Podiatrist
  - Optometrist
  - Nurse-Midwife
- Primary Care Case Management Services
- Prevention Services
  - Periodic Well Child Screens
  - Adult Physicals
  - Mammography Services (women age 40 and over only)
  - Diagnostic Screening Clinics
  - Medical Social Services
  - Prevention and Health Assistance Benefits
    - Smoking Cessation Aids
    - Weight-Loss Assistance
    - Nutrition Services (including Diabetes Education)
  - Laboratory and Radiological Services
  - Prescription Drugs
  - Family Planning Services
- Laboratory and Radiological Services
- Prescription Drugs
  - Family Planning Services
  - Mental Health Services
  - Inpatient Psychiatric Services
  - Outpatient Mental Health Services
    - Psychotherapy Services
    - Evaluation and Diagnostic Services
- Home Health Care
- Physical and Occupational Therapy
- Respiratory Care Services (children only)
- Speech, Hearing, and Language Services
- Medical Equipment, Supplies, and Devices
- Vision Services
- Dental Services
- Services provided by:
  - Rural Health clinics
  - Federally Qualified Health Centers
  - Indian Health Services Facilities
  - Independent School Districts
- Medical Transportation Services
- EPSDT Services (children only)
- Pregnancy-Related Services

SERVICES COVERED IN THE ENHANCED PLAN

All services covered in the Basic Plan, plus:

- Nursing Facility Services
- Personal Care Services
- Home & Community –Based Waiver Services
- Service Coordination / Case Management Services
- Hospice Care
- Intermediate Care Facility for People with Mental Retardation (ICF/MR)
- Developmental Disability Agency Services
- Expanded Mental Health Services/Psychosocial Rehabilitation
- Private Duty Nursing

SERVICES COVERED IN THE MEDICARE/MEDICAID COORDINATED PLAN

All services covered in the Medicare Advantage Plan, plus:

- Personal Care Services
- Expanded Nursing Facility Services
- Intermediate Care Facility for People with Mental Retardation (ICF/MR)
- Medicare Excluded Prescription Drugs
- Prevention and Health Assistance Benefits
  - Smoking Cessation Aids
  - Weight-Loss Assistance
- Psychosocial Rehabilitation
- Expanded Dental Services
- Medical Transportation
- Specialized Medical Equipment & Supplies
- Developmental Disability Services
- Home & Community Based Waiver Services

TABLE 2. TIMELINE OF POLICY IMPLEMENTATION

July 2006 • Basic and Enhanced benefit plans implemented (phased in at renewal over following year) • Children with income between 134-150 percent of the FPL transferred to separate Children's Health Insurance Program • Asset test for children eliminated • Diabetes pay-for-performance pilot begins in Boise and Pocatello • Adult wellness exam benefit added • Reimbursement rate for well-child exams increased to level of commercial insurance • Expedited "Healthy Connections" connects participants to a provider within 30 days of enrollment • Best price negotiated for incontinence supplies
September 2006 • "Healthy Schools" Initiative begins supporting salaries of nurses in schools with a high percentage of low-income students
October 2006 • Idaho joins multi-state drug purchasing pool, TOP$ • Aging Connections pilot, long-term care financing policy changes, and estate recovery policy changes begin
December 2006 • Monthly premiums begin for families earning 134-150 percent of the FPL ($10/member/month).[13] • Premium assistance rules relaxed: removes requirement that employer contribute 50 percent of spouse premium to be eligible • Consumer-directed care/self-determination program begins
January 2007 • Preventive Health Assistance (PHA) programs implemented (smoking cessation, weight loss, wellness) • Medicaid Buy-In for workers with disabilities begins enrollment
February 2007 • Co-payments for non-emergent use of ER and inappropriate ambulance use go into effect
April 2007 • Medicare-Medicaid Coordinated Benefit plan implemented
July 2007 • Phase-in of new benefit plans complete
September 2007 • Dental plan outsourcing begins
October 2007 • Pay-for-performance programs expanded to all Federally Qualified Health Centers except Glenns Ferry and Idaho Falls
November 2007 • Long-term care Partnership program begins

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NOTES

[1] The project also examines DRA-related policy changes in Kentucky.

[2] The American Recovery and Reinvestment Act of 2009 provided a temporary increase in the federal matching rate of 6.2 percentage points, plus additional increases based on the increase in the unemployment rate in each state. The Government Accountability Office estimates that this will result in an additional $300 million in federal funds to Idaho between FY2009 and FY2011 (Kaiser Commission on Medicaid and the Uninsured 2009).

[3] The Title XXI enrollment figure includes both children in the Medicaid expansion program and the separate Children's Health Insurance program.

[4] An additional $21million was spent on CHIP in 2005 (Centers for Medicare and Medicaid Services 2008). Considering Medicaid and SCHIP spending together, children accounted for 22 percent of combined spending in 2005.

[5] Enrollees with unknown eligibility category constitute another 1 percent of spending.

[6] Additional reforms included Aging Connections/Long-term care coordination financing reforms, self-directed Home and Community-Based Services (HCBS) waiver amendment, and Medicaid buy-in for disabled workers.

Idaho began a pilot program in the northern region of the state called Aging Connections, which was designed to counsel elderly beneficiaries on long-term care insurance options and end-of-life issues. Long-term care coordination was an integral part of reform and was addressed mostly through the Medicare/Medicaid Coordinated Benchmark Plan. The LTC Partnership program (SPA 06-010) makes Medicaid the payer of last resort for long-term care insurance, and changes to Medicaid's estate recovery program allow Medicaid to obtain personal assets in the form of bank accounts or stocks and to foreclose estate liens under certain circumstances (SPA 06-011).

An amendment to the state's HCBS waiver gives participants with developmental disabilities more flexibility to decide the frequency and source of supports they receive and to negotiate the payment rate. The change is modeled after the National Cash and Counseling Demonstration.

CMS approved Idaho's SPA to create a Medicaid buy-in program to incentivize disabled enrollees to enter or reenter the workforce. Disabled workers whose income exceeds 133 percent of the FPL are allowed to continue their Medicaid coverage with cost-sharing responsibilities.

[7] Enrollment in the Medicare-Medicaid Coordinated Plan began in April 2007. By July 2007, 13,416 participants were enrolled in this plan and 873 had elected to be in a Medicare Advantage Plan. About 35,000 participants were still awaiting their renewal date to be placed into one of the three plans in July 2007 (Idaho Department of Health and Welfare "Medicaid Status Report Update" 2007).

[8] Tobacco cessation products are not covered under Medicaid, so beneficiaries can only access them through the PHA program. All Idahoans also have access to a state-sponsored quitline.

[9] Payments are given for conducting each test/procedure annually, with the exception of A1C, which can qualify for up to 4 payments of $10 per year if the patient's A1C level is above 7.

[10] Access refers to the share of beneficiaries who received a dental service; utilization refers to the number of services received by beneficiaries.

[11] In July 2006, Medicaid also began a new process of purchasing medical supplies at one negotiated low price for all providers. The state began with the purchase of incontinence supplies, which experienced a 23 percent reduction in cost in the first year (Department of Health and Welfare, "Medicaid Reform Status Report" 2007).

[12] The state began its Aging Connections pilot in October 2006 in three Idaho communities. By the end of 2007, nearly 700 participants were receiving long-term care financing counseling through the program and the state avoided an estimated $230,000 in costs associated with long-term care (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). The changes to Medicaid's estate recovery program went into effect in July 2006 and collected nearly $400,000 in the first 18 months of the new program (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). The Long-term care Partnership program began in November 2006 and sold 252 policies in the first year. These private policies protect a portion of participants' assets if they become eligible for Medicaid-financed LTC insurance. The Medicaid buy-in program for workers with disabilities was implemented in January 2007 and had about 350 participants by the end of the calendar year (Department of Health and Welfare, "Medicaid Reform Status Report" 2007). The consumer-directed care option for HCBS recipients was implemented in December 2006 and at the end of the first year had 16 participants with completed plans and 36 participants who had completed training.

The new non-emergency transportation broker only serves regions 5, 6, and 7, and the previously existing transportation services remain in effect in rural Idaho counties.

[13] Families earning 150 to 185 percent of the FPL pay $15/member/month, which pre-dates reform.

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SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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