THE CAPITOL FORUMS
On Health and Medical Care

Restructuring Health Care Delivery in New Jersey

background information for the discussion at the

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RESTRUCTURING HEALTH CARE DELIVERY IN NEW JERSEY

An issue brief prepared for discussion at the April 26 Capitol Forum

THE ISSUE:

What new reforms are on the table as New Jersey begins work toward a revised structure for the delivery of health care?

Responding to new opportunities and the successes of other pioneering states, New Jersey is considering a significant restructuring of its state health care delivery system. Will the state pursue a Section 1115 waiver and, with it, the ability to broaden the numbers served by Medicaid while moving that delivery method more completely into a managed-care environment?[1] How can state-delivered health care be extended to the persistent and growing population of uninsured residents whom Medicaid fails to reach? In a time of finite public funds, how can the state re-engineer the system to deliver more health care for the same amount of money? What will New Jersey's new methods mean for the quality as well as the quantity of health care?

INTRODUCTION

New Jersey enacted sweeping health care reforms in 1992, following a new approach dedicated to reaping the benefits of a less-regulated private market. Cost controls were abandoned in the belief that competition would prove a more effective check on spiraling expenditures. To assist two population groups with notoriously low rates of insurance coverage, the state developed two new private markets -- one for individuals without access to group insurance, and one for the employees of small businesses.

Meanwhile, the Legislature established a program providing subsidies on an income-based sliding scale in order to bring private insurance within easier reach of lower-income residents.

[1] Section 1115 of the Social Security Act authorizes waivers of specified provisions of Medicaid and public assistance statutes to carry out demonstrations promoting the goals of these programs.

Some three years later, the Whitman administration is considering further refinements and improvements that would add significant new dimensions to New Jersey's state health care structure.

THE PROCESS

The architects of the state health care system are readying a series of proposals aimed at improving the delivery of services to the state's lower income residents (recipients of Medicaid as well as working people with incomes insufficient to cover costly insurance premiums). The Division of Medical Assistance and Health Services (Medicaid) in the Department of Human Services set the process in motion last summer as it began to study the experience of other states that used Section 1115 demonstration waivers to broaden Medicaid coverage to new groups of clients. Also central to the discussion is the Office of Health Care Reform Initiatives in the Department of Health. Medicaid is also seeking out a range of other voices launching interdepartmental discussions about possible new methods and directions.

In essence, what began as a look at a Section 1115 waiver project has evolved into an approach to more general health care reform. The participants have begun looking at such questions as how to simplify the now-complex procedures for determining Medicaid eligibility, how to provide mental health coverage, and how to pool the state's health care purchasing power for maximum advantage.

Beginning this summer, Medicaid plans to take a package of concepts and goals around the state to the principal health care constituencies -- provider associations, client advocacy groups, community organizations, etc. -- to solicit feedback and suggestions, which it will take into account as it formulates a concrete plan. Guiding this deliberative approach is a lesson learned in states such as Tennessee, where dramatic health care changes were instituted quickly and, in the view of critics, without sufficient public input and a proper amount of time for a smooth transition.

Whether any of the resulting measures will require legislation is now

unclear. The answer to that depends on precisely what new policies and procedures are proposed, and on whether legislation is deemed necessary by the Attorney General's office, which is also among the parties with which Medicaid is consulting.

GOALS AND DIRECTIONS

MEDICAID MANAGED CARE

As part of general effort to hold down the rate of increase in Medicaid expenditures, New Jersey and many other states are moving toward a managed-care approach to the delivery of Medicaid benefits to their low-income populations. Roughly $4 billion is spent annually on Medicaid benefits for New Jerseyans -- $2 billion by the state and $2 billion by the Federal government.

Proponents of managed care extol the effectiveness of HMOs (health maintenance organizations), PPOs (preferred provider organizations) and other managed care entities in containing costs through the elimination of unnecessary treatments. In addition, they praise the preventive medicine it promotes and the long-term benefits that derive therefrom. Since 1984, managed care has been an option for New Jersey residents who receive Aid to Families With Dependent Children (and who are thus automatically eligible for Medicaid through New Jersey's state-operated Garden State Health Plan), but only in recent years have significant numbers volunteered to exchange their fee-for-service insurance cards for membership in HMOs and other managed-care organizations.

The popularity of managed care among AFDC recipients has peaked in the last 12 months, more than tripling the number of voluntary enrollees. Now, roughly 80,000 of the 425,000 AFDC and AFDC-related Medicaid clients in New Jersey are in managed care, and their ranks are growing by 2 percent to 3 percent a month. ("AFDC-related" refers to a category of client families with incomes just above the threshold for AFDC eligibility.) The dramatic growth is attributed to Medicaid's commitment to increased public awareness of managed care options and

the ever-greater availability of managed care. Because HMOs are scarcer in the state's less populous regions, AFDC managed-care enrollees are concentrated in the heavily urbanized counties of Camden, Essex, and Hudson.

A next step would be mandatory managed care for Medicaid families, a move the state plans to make later this year. New Jersey is awaiting approval of a Federal 1915(b) waiver to allow for the institution of mandatory managed care for AFDC and AFDC-related populations in Camden, Gloucester, and Hudson counties. Medicaid views that as a foundation for the possible expansion of mandatory managed care for Medicaid recipients statewide, toward a target of roughly 400,000 AFDC and AFDC-related Medicaid clients. (To enroll all 425,000 in managed care is considered unrealistic, since some, such as those being treated by non-HMO physicians for a terminal disease, will inevitably qualify for special exemptions.)

SECTION 1115 WAIVERS

Massachusetts this month became the most recent state to be granted Federal approval to modify its Medicaid program as a statewide demonstration under Section 1115 of the Social Security Act. It thus joined Kentucky, Oregon, and Tennessee and several other states that have sought and gained permission under the Section 1115 waiver program to refashion Medicaid delivery to cover more people. (See the National Health Policy Forum Issue Brief No. 662 for further details on Section 1115 waivers.)

Though the particulars vary among states, their waiver programs share the use of mandatory managed care for traditional (i.e., non-elderly) Medicaid recipients. The dollars saved are recycled to allow a coverage expansion at no additional cost. (Federal Medicaid funds are delivered on a match basis, with rates varying from state to state. In New Jersey, the Federal government matches state Medicaid expenditures dollar for dollar; the Federal match is more generous less affluent states.)

To qualify for a Section 1115 demonstration waiver, states must, as the

name implies, attempt to demonstrate or test a new method of health care delivery. A key component of a New Jersey demonstration project would likely be advanced quality improvement techniques. That means the state would collect, in a central repository, comprehensive data on patient outcomes to gauge the effectiveness of a broadened Medicaid managed care program in improving clients' health. Another area of inquiry under a Section 1115 waiver program could be long-term care alternatives.

Until recently, New Jersey's reform considerations had as the centerpiece the Section 1115 demonstration waiver approach. However, a study of other states' experiences and a recently changing national climate around the Section 1115 waivers have left state officials unconvinced. Clouding the picture is the possibility of regulatory movements within the Health Care Financing Administration (the agency responsible for Medicaid) that could allow states more freedom to restructure Medicaid delivery without resorting to the demonstration waivers.

Whether the state will adopt the Section 1115 waiver approach depends on developments in Washington and on the feedback Medicaid receives as it begins the dialogue with its constituencies and other key players later this year.

MEDICAID ELIGIBILITY

Other pioneering states have broadened Medicaid coverage to their uninsured populations by simplifying eligibility, a direction under consideration in New Jersey. Eligibility is now determined by a complex set of factors, including income, assets, category tests, and other characteristics -- a process state officials describe as cumbersome and burdensome. How to simplify it? State officials are considering a straight income test. Simplifying eligibility is seen as a way to save administrative costs as well as ease the red-tape burdens on clients. In addition, easier eligibility standards are necessary if a broader population is to be served.

In other states, modification of eligibility has allowed the expansion of coverage to such people as non-disabled childless couples and single adults, and to uninsurable people who do not satisfy Supplementary Security Income (SSI) disability requirements.

BEHAVIORAL HEALTH CARE

As part of this effort to stretch the coverage umbrella, Medicaid is considering an expansion of Medicaid managed care services to behavioral health care --treatment of mental illness, alcohol and substance addiction, etc. -- which is now largely beyond the scope of Medicaid.

The application of managed care to this realm is problematic in some ways; treatment decisions for addictions and mental health diseases are often subjective, making this area a difficult fit for the precision approach of managed care. Nevertheless, reform architects see possibilities for improvements through greater use of alternative service settings, such as non-hospital detoxification centers and outpatient after-care for the treatment of alcoholism, for example. Removing such treatment from the expensive acute care setting is only part of the desired benefit. By providing patients more effective treatment, there presumably will be fewer relapses and, therefore, fewer costly returns to the care system.

THE HEALTH ACCESS PROGRAM

Also under consideration is an expansion of Health Access New Jersey (Access), which was created in the reforms of 1992 and scheduled to debut this month. Aimed at lower-income residents who do not qualify for Medicaid, the program provides subsidies to help participants buy private insurance from the state's individual insurance market The level of one's own contribution is based on income. Eligibility is restricted to individuals and families with gross incomes up to 250 percent of the Federal poverty level ($18,675 for individuals and $37,875 for a family of four). If the program proves successful in its first year, an expansion could be considered through the institution of higher eligibility ceilings and the coverage, possibly, of behavioral health care.

The Access program is geared toward people making the transition from welfare to the work force, for whom loss of insurance is a formidable obstacle. Helping that group maintain health care after welfare is one of the principal goals as the new reform plan is assembled, which would make adjustments in this program a high priority under a reform plan.

However, funding remains an important and unanswered question. The Access program is operating this year on $50 million from the Unemployment Insurance Trust Fund, but no funds are allocated for 1996. State health officials acknowledge that any state health care reforms must be revenue neutral in today's political climate. Thus, the key to an expanded Access program lies in the achievement of new efficiencies and in the ability of managed care to deliver on one its most touted promises -- that it can reduce expensive, acute medical problems with less expensive preventive care.

POOLED PURCHASING

Any discussion of new efficiencies leads inevitably to the issue of pooled purchasing. The two major purchasers of state health care are the Department of Treasury -- which provides health benefits for state workers, as well as many county and municipal employees who participate in the State Health Benefits Plan -- and the Medicaid program. Together, they purchase health care for more than one million state residents, and the figure could approach 1.5 million people if Medicaid coverage expands.

The architects of state health care are increasingly attracted to the idea of joining the separate state purchasers in a united front. The economies of scale, they believe, would give them greater leverage and the ability to attract more competitive bids. That, in turn, would help the state achieve two major goals -- the extension of Medicaid eligibility to more people and a broadening of the Access program -- without any new infusions of funding.

LONG-TERM CARE RECIPIENTS

A reality of the Medicaid program today is that roughly three quarters of the funds in New Jersey -- approximately $3 billion -- are spent on a client group that comprises just one quarter of the client total. That group is the population of elderly, long-term care recipients, who become Medicaid-eligible after their Medicare benefits are exhausted by expensive nursing home bills and other expenses. This group is now largely beyond the reach of managed care.

The designers of the state's health care delivery system believe there are ways that the application of managed care principals could yield better care for this group as well as more efficient use of Medicaid funds. As they do in the case of behavioral health care, they believe alternative care methods offer great, as-yet unrealized potential. In the case of elderly and disabled population, those alternatives include assisted-living communities, home care and adult day-care.

HEALTH CARE QUALITY

A primary goal of the forthcoming reform effort is attention to the quality, not just the quantity, of state-delivered health coverage. The reform architects believe managed care offers more than savings; they say it promises a "health-care home" for Medicaid recipients and a strengthened emphasis on preventive health care. Any changes in the state's health care structure will be expected to deliver improved outcomes, i.e., healthier people.

An important component of this philosophy is the expectation that sophisticated, effective tools must be developed to monitor and measure these all-important outcomes.

CONCLUSION

The failure of comprehensive federal health care reform has left states looking inward as they attempt to respond to imperatives in the delivery of health services to their residents. But as New Jersey attempts to bring more and better health care to its residents, it is coping with a 1990s political reality: No reform or new approach may cost government more money. In this challenging environment, state reform architects are turning to managed care and its promise of better and more cost-effective care.

QUESTIONS FOR DISCUSSION

1. Given the number of New Jerseyans without health insurance, approximately how many more residents can a reconfigured cost-neutral system cover?

2. Approximately $3 billion of the $4 billion Medicaid budget is used for chronic and long-term care. How will any reformed system impact the recipients and the rate of growth of the costs?

3. How does a publicly reformed access and fiscal system relate to a market place reformed delivery system?

APPENDIX

SECTION 1115 DEMONSTRATION WAIVERS

Over recent years, an increasing number of states have sought to alter their Medicaid programs by expanding eligibility and changing the way care is organized and delivered. Since many of these changes run afoul of Federal regulatory requirements, states have had to seek special waivers to try their new methods without jeopardizing Federal match funding. Many states have found it most advantageous to carry out their new programs as statewide demonstrations under Section 1115 of the Social Security Act, which authorizes research and demonstration projects that promote Medicaid goals.

This avenue has become particularly popular since 1993, when the Secretary of Health and Human Services revised the review and approval process for Section 1115 waivers to allow projects on a statewide basis. Previously, only more limited projects were approved.

Despite the popularity of Section 1115 waivers, this approach to health care reform has prompted criticisms and legal challenges. Some advocates for the poor have charged that Section 1115 waiver programs are using bureaucratic loopholes to carry out significant reform without proper amounts of legislative or public input. One of two recent lawsuits, meanwhile, filed by the National Association of Community Health Centers, challenges the statutory authority of Health and Human Services Secretary Donna Shalala to approve the waivers. In a second case, from California, a U.S. Court of Appeals vacated a limited waiver granted by Shalala on the grounds that she failed to give due consideration to potential harm to families participating in a waiver project.

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