Department of Human Services

Articles in Today's Clips

Friday, January 6, 2006

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Prepared by the DHS Office of Communications (517) 373-7394

*Important story at this spot

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New prescription drug plan causing a few headaches

By SARA ROBINSON
Saginaw News Staff Writer

For those who have enrolled in the Medicare Part D prescription drug program, the first day of the New Year marked the start of prescription drug coverage.

Meanwhile, pharmacies have encountered additional work and a few headaches as enrollees in the program filled their first prescriptions under their new prescription drug plans.

"It's a hardship, not only on the patients, number one, but the pharmacies," said Mary McLean, co-owner of McLean Pharmacy in Rogers City.

According to Kristine Spicer, a pharmacist at LeFave Pharmacy and Home Medical Equipment, quite a few new enrollees in the Medicare Part D program haven't yet received their prescription drug benefit card.

"A lot of patients are not getting their cards on time, so they have incomplete information about their coverage," she said.

At LeFave Pharmacy, a special software program has eased the burden somewhat by allowing pharmacists to do a search for information using the enrollees Social Security number.

"If they're enrolled, and we have their Social Security number, we have been able to get all their information without seeing the card," Spicer said, adding the computer program was only able to pull up limited information.

"There are a lot of different plans out there," she said. "We have to kind of trial-and-error punch these different plans in hoping to get the right one."

At McLean Pharmacy, there also have been a number of enrollees who haven't received cards. McLean said approximately 50 percent of the customers she's served since the program became effective still don't have cards.

She said attempts to use pharmacy helplines provided by the different insurance plans have proven largely unsuccessful, since pharmacies across the state and nation have swamped helplines with calls.

Dealing with insurance companies has left the pharmacy staff with less time to focus on drug counseling and customer service, McLean said.

In addition to creating headaches for pharmacists who have to search to retrieve patient information, the prescription drug plan created additional work for pharmacies before coverage even began.

Spicer said a secretary at LeFave spent several weeks prior to the coverage start date enrolling in the many different Medicare prescription drug policies. There are over 100 different plans nationwide and around 40 different plans in use in Michigan, according to Spicer.

The prescription drug program has created a fair amount of work at Ossineke Pharmacy, but pharmacist Terry Krumbach said adjusting to the new program hasn't been as difficult as he anticipated.

"It's going better than I thought it would," he said.

He said additional work has been created for the pharmacy because many patient profiles have to be altered.

"People that didn't have insurance before now have insurance. Some of the people that had some forms of Medicaid now have a form of Medicare," he said.
Krumbach said people who haven't had cards have been advised to contact their providers to obtain the necessary information.
"The companies have been pretty good with the people I've told to call, as far as giving us the numbers we need to bill the things," he said.
Since there are a multitude of different plans, and since different plans cover different drugs, learning which plans cover which drugs may present more work for pharmacists in the coming weeks, Krumbach said.
"That's sort of a learning process, and that's going to continue to be a learning process for awhile until the pharmacists and the physicians work with some of the cards and see exactly what's covered," he said.

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Medicare help rolls into town

Friday, January 06, 2006

The Grand Rapids Press

HOLLAND -- Holland is the next stop of a statewide campaign by Meijer, Blue Cross Blue Shield of Michigan and Blue Care Network to educate thousands of Medicare-eligible individuals and their families on the new Medicare programs -- the Medicare Part D prescription drug benefit and Medicare Advantage plans. "The Blues Cruiser" will be making a stop in front of the Meijer store, 3320 W. Shore Drive, today until 6 p.m. and Saturday from 9 a.m. to 2 p.m. No reservations are required. Blues product specialists will discuss changes in Medicare, and from a Meijer pharmacist will talk about how to better manage prescriptions.

Pew Center on the States

Special Report on Medicaid

2006

Pew Center on the States Special Report on Medicaid 2006

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www.pewcenteronthestates.org

States are pivotal players on a wide range of public policy issues and have repeatedly demonstrated their ability and willingness to take innovative approaches to solving important problems faced by the public. Given the impact that state policy makers' decisions have on both individual citizens and the country at large, the stakes in this arena are very high. **The Pew Center on the States**, an operating division of **The Pew Charitable Trusts**, seeks to identify and advance effective public policy approaches to critical issues facing the states by analyzing real-world experience, highlighting examples of what works and what doesn't, calling on diverse perspectives, and collaborating with a wide range of partners and funders.

The report that follows represents the first major accomplishment of the Center, which is overseen by **Susan Urahn**, director of State Policy and Education at the Trusts. The report was designed, managed and edited by **Katherine Barrett** and **Richard Greene**, both senior project coordinators with the Center. Their Trusts-funded report about health care won the National Institute for Health Care Management's Health Care Journalism Award in 2005.

Penelope Lemov, *Governing* magazine's associate editor and health care columnist, was executive editor of the project.

The research/writing team was led by **Rebecca Adams**, a reporter at *Congressional Quarterly* who was chosen for the national Kaiser Family Foundation health journalism fellowship in 2003-2004. **Gary Enos** has contributed to many publications and served as editor of the magazines *Behavioral Healthcare Tomorrow* and *Addiction Professional*. **Jenny Mandel** has written for numerous publications, non-profit groups and international organizations on topics including childhood health and Internet technology. **Misha Segal** has worked on policy issues at the Urban Institute and has been an independent consultant for health insurance and public health associations.

Governing staffers contributing to this report include: design director **Jandos Rothstein**, art director **Bonnie Becker**, production manager **Tonya Namura**, managing editor **Anne Jordan** and editorial assistant **Ben Delman**.

The report was carefully screened by two nationally respected Medicaid experts: **Cindy Mann**, research professor at the Health Policy Institute at Georgetown University and a key Medicaid official during the Clinton administration, and **Vernon Smith**, a consultant with Health Management Associates and a former Medicaid director in Michigan.

Illustrations by Wesley Bedrosian

Bridging the Gap Between Care and Cost

States are pivotal players on a wide range of public policy issues and have repeatedly demonstrated their ability and willingness to take innovative approaches to solving important problems faced by the public. Given the impact that state policy makers' decisions have on both individual citizens and the country at large, the stakes in this arena are very high. The Pew Center on the States, an operating division of The Pew Charitable Trusts, seeks to identify and advance effective public policy approaches to critical issues facing the states by analyzing real-world experience, highlighting examples of what works and what doesn't, calling on diverse perspectives, and collaborating with a wide range of partners and funders.

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Pew Center on the States
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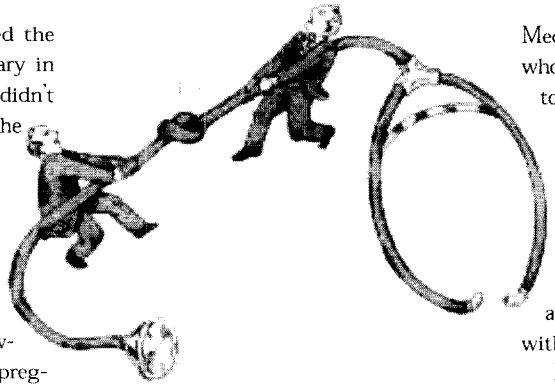
The Great Debate

The high cost of Medicaid puts it in the eye of a storm.



Medicaid officials celebrated the program's 40th anniversary in July, although the occasion didn't feel much like a birthday party. With the federal government drowning in debt and states just emerging from a service-choking recession, the program is at the center of a national debate over how to cut costs while maintaining the safety net for roughly 58 million Americans, including the disabled, low-income children and their parents, pregnant women and seniors. As Drew Altman, president of the Kaiser Family Foundation, puts it, the Medicaid discussion is "about our beliefs about the role of government and our obligations to one another."

Even though Medicaid growth rates have slowed in the past year or two—the economy has improved and states have taken some steps to control costs—Medicaid spending is now more than 21 percent of total state budgets, threatening to drain resources from other key state responsibilities. Overall, the price tag was $329 billion last year, of which the federal government paid 57 percent and the states the rest. Spending growth is likely to be 7.7 percent a year over the next decade, according to Congressional Budget Office estimates. "Medicaid," Virginia Governor Mark Warner told the National Governors Association in July, "could actually bankrupt every state in the country before 2020 unless we can get a handle on it."

That dire prediction will not come to pass. Dramatic changes in some states' Medicaid programs have already taken place, and more are inevitable in the near future. High-level commissions and study groups are pursuing broad-scale reform. At the federal level, Health and Human Services Secretary Michael O. Leavitt hand-picked 15 voting members for a commission charged with submitting a report with ideas for the future of the Medicaid program. It was also asked to carve $10 billion out of the Medicaid bill over the next five years and met that deadline in September with a recommendation of $11 billion in savings. It suggested such cost controls as new formulas for prescription drug reimbursement, tiered drug co-payments for Medicaid recipients and barriers to families who siphon off elderly relatives' assets in order to qualify them for Medicaid-reimbursed long-term care. Several months before, the National Governors Association issued a preliminary report recommending some of the same ideas plus a number of others. The NGA also called for more flexibility for state officials to balance the delivery of quality health care with the need to tame costs.

Despite those efforts, many state lawmakers, Medicaid officials, advocates and recipients remain deeply worried about the future of the nation's largest health care program, particularly because some of the cost-cutting proposals on the table threaten to do more harm than good. But the silver lining here is that a number of states are exploring new ways of doing business, developing better approaches to service delivery, creating a track record of success—and asking the federal government to support their innovations.

The articles that follow look at what is happening in state Medicaid programs in specific areas. They are the result of months of careful study by the Pew Center on the States, a new operating division of The Pew Charitable Trusts. This report affords an opportunity to analyze the real-world experiences of states, highlight examples of what works and what doesn't, and inform a crucial policy debate that will affect the lives of millions of Americans.

The Challenge of Change

Medicaid's relentless growth is its weakness—and its strength.

Medicaid is one of the sick old men of social policy—worrying about how expensive things are getting while complaining about its aches and pains. Forty years of providing health care for the disabled, poor and elderly, and what does it get? Threats to cut billions from its budget and to limit its reach and benefits.

In Medicaid's happier days—a mere six or seven years ago—budget-flush states gave the program a jolt of youthful elixir. They increased income levels for eligibility, cut the red tape that had restrained signups and searched for citizens who were qualified for the program but hadn't applied. What's more, with the State Children's Health Insurance Program, six million uninsured children who weren't eligible for Medicaid were awarded a Medicaid-like package of health care coverage. The uninsured rate among low-income children dropped by a third between 1997 and 2003, despite the onset of a recession in 2001.

Those heady days are no more, in part because health care itself has become so costly. While inflation was in the 1.5 to 3.3 percent range from 2000 to 2003, health care spending went on a wild ride: Prescription drug costs rose 17.1 percent annually and inpatient hospital costs went up 11 percent a year. During the first few years of this decade, the economy slid into a downturn, causing Medicaid caseloads to grow. In the past five years, they have increased by 40 percent, taking on not only people who lost their jobs and became poor enough to qualify for the program but also employees of large companies that have become increasingly unwilling to pay the high costs of health insurance for many of their workers—a problem that will only grow as the nation continues to turn to a more service-oriented economy.

State revenues have not been able to keep pace with Medicaid's unremitting growth, and the federal government, with fiscal problems of its own, has grown ever more unhappy about footing its open-ended share of the bill. Medicaid's mission, meanwhile, is formidable. It finances not only acute care for low-income families but also long-term care and support for individuals with disabilities. Even more challenging is the demographic future. The number of elderly Americans is growing steadily, increasing demand for expensive services such as nursing home beds, other long-term care facilities or home-based care. Already, about one-third of Medicaid's budget goes to long-term care.

There is pressure from all levels of government to rethink all aspects of the program. The program is not fiscally sustainable, and things are not likely to get better without intervention. The net result is that states and the federal government are now X-raying the Medicaid system. What fills many advocates for Medicaid and for low-income beneficiaries with dismay is that the mechanism being used for the review may ignore the brain and heart of the program and focus exclusively on the wallet.

Balancing the Books

There is, of course, a profound connection between money and care. When it comes to reimbursing its medical providers, for instance, Medicaid is stingier than either Medicare or commercial insurance. Compensation cuts have become one of the most expedient means for saving dollars.

By low-balling compensation, however, the program ends up reducing the number of providers willing to take care of Medicaid patients. According to the California Health Care Foundation, only about half of California physicians participate in Medi-Cal, and the number is shrinking. A focus group of Medicaid participants with disabilities reported difficulty locating providers willing to accept Medi-Cal, particularly specialists.

The cause and effect between reimbursement rates and access to physicians is clear. For many of the fiscal fixes for Medicaid's problems, the unintended consequences of change may be harder to see.

The nation's health care system is often likened to a balloon: squeeze one part of it and another portion expands. This is true in Medicaid as well. Eliminate dental care for adult patients, for instance, and you may wind up

treating them for malnutrition or reducing their chances of finding a job that might take them off of Medicaid. Reduce the number of asthmatics who receive preventive treatment through Medicaid, and the same people may wind up in emergency rooms for far more expensive care.

Then there's the relationship between Medicaid and private insurance. When an individual who has been cut from Medicaid enters a hospital for an emergency, that person cannot usually pay the bill. But hospitals have to balance their books. As a result, 42 percent of the cost of treating uninsured patients is shifted to private insurance, according to a 2004 report issued by the Urban Institute. That can and does raise private insurance rates. Partners HealthCare, a major academic health system in Boston, reports that Medicaid cuts in Massachusetts have required it to raise charges to commercial health plans by 4 percent.

There's a vicious cycle here. When health insurance costs increase, private coverage tends to fall, Medicaid absorbs some of those who lose coverage, and the ranks of the uninsured grow. But if insurance picks up only 42 percent of the cost of treating the uninsured, where does the other 58 percent come from? About a quarter of it is paid by the individuals themselves. Most of the rest comes from the states and the federal government, who pony up money for hospitals that provide a significant amount of charity care.

In the final analysis, as much as cuts in Medicaid may seem like real savings for the states and federal government, the bills for uncompensated health care don't go away. They're paid by average Americans and by a variety of state and federal programs. The illusion of real savings comes because those expenses don't flow through just one program and aren't easily tracked.

Questioning Value

Although evaluations of Medicaid programs are plentiful, there are enormous holes in the kind of analytic information policy makers need to make positive change. Relatively few public dollars are spent on determining which treatments work best and how to encourage their use. Often, Medicaid's practices are driven by what is cheapest or easiest, what is politically acceptable and what has been done before—rather than through a determination of what is most effective.

Even when pilot programs are successful, follow-up on those successes is often short-changed, so good ideas aren't replicated as much as they should be. The federal government has focused relatively little analytic attention on Medicaid, given the size of the program. "Compare the literature and resources going into Medicare versus those going into Medicaid," says Andy Schneider, a former congressional aide who is currently a Medicaid consultant. "There's just not an investment in Medicaid."

Part of the issue is that states don't have the luxury of waiting to see if a fresh idea will work. "You don't do a control group. You don't have a counterfactual," says Alan Weil, executive director of the National Academy of State Health Policy. "You do it because you think it'll work."

Vernon Smith, a health care consultant with Health Management Associates who was a Medicaid director in Michigan, argues that at the very least, Medicaid programs have an obligation to the taxpayers to get the best possible value for the money spent. It's hard to argue with that logic. But his point is easier understood than accomplished. Consider this: The Centers for Medicare & Medicaid Services (CMS) will pay up to 90 percent of any costs required to streamline or improve claims management. Yet a number of states haven't taken advantage of what would seem to be a golden opportunity. Why? "Even finding just the 10 percent is expensive," says South Carolina Medicaid director Robert Kerr.

An Age-old Problem

So far, states have relied much more on cuts in services for the relatively healthy and young adult beneficiaries rather than the aged or those with disabilities. Politically, it's easier. It's also an illusion. Senior citizens and people with disabilities make up 25 percent of the Medicaid population but consume 70 percent of the costs.

Clearly, any attempt to constrain Medicaid's growth and spending has to address the elderly and disabled—a tricky task since both groups have strong advocacy networks. "You can't balance your budget for this program on the backs of welfare recipients," Smith says. "There just aren't enough of them, and they are not very expensive people to serve."

A major component of spending for the disabled and elderly has been institutional costs for long-term care. But there is a large group of elderly and disabled patients that lives outside of long-term care institutions, and 40 percent of the spending for this group has been on hospital care—more than half of the individuals were hospitalized within the previous year. Other big expenditures were for home health care, at 24 percent of spending, and prescription drugs, at 18 percent.

Then there is the issue of "dual eligibles"—Medicaid seniors who are also eligible for Medicare. It's an Alice in Wonderland universe. The states, through Medicaid, are responsible for the bulk of long-term care for older Americans while the feds, through Medicare, provide most of the acute care. Medicare covers all elderly Americans, of course, while Medicaid is generally provided only to those with little or no money.

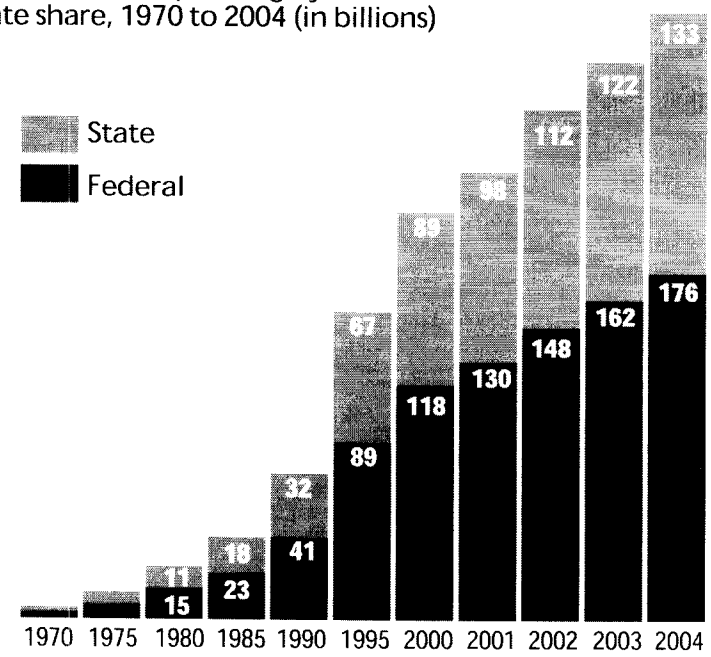
"If, at age 85, you have the good judgment to pass from this earth in an explosion of acute care services, Medicare will be perfectly willing to pay $100,000 to a hospital in a non-means tested program, with modest cost sharing," says James Tallon Jr., chair of the Kaiser Commission on Medicaid and the Uninsured. "God forbid that you choose dementia as the route of departure." In that case, Tallon notes, you kick into a national policy that worries about whether you should pay the cost of care out of your reverse mortgage or whether the state can go after your assets or how much cost sharing the state can get out of you. "That doesn't make any sense as a national policy," Tallon says.

Federal Tension

The two programs may not play well together, but neither do the states and their Medicaid partners, the feds. There is an in-

The Medicaid Tab

Total Medicaid spending by federal and state share, 1970 to 2004 (in billions)



Sources: Congressional Budget Office and Federal Funds Information for States

creasing tension between the two. Governors are eager to see Medicare pick up more of the bill for older Americans. At the same time, the federal government is concerned about the ways in which states have amplified their efforts to "maximize federal dollars." In 2004, for instance, 34 states—up from 10 in 2002—used contingency fee consultants to help increase federal Medicaid reimbursements. According to the Government Accountability Office, Georgia paid a consultant $82 million between 2000 and 2004 to generate $1.5 billion in new federal Medicaid dollars.

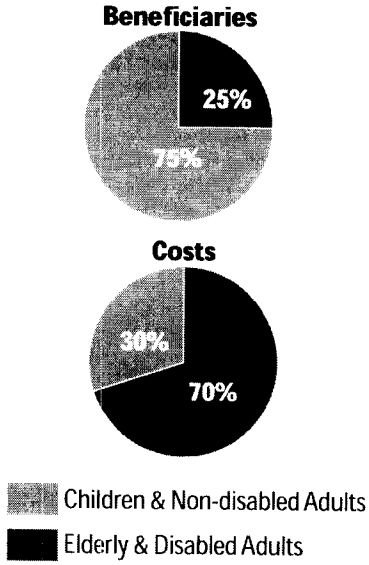
Some of the efforts to get a federal match for state expenditures are based on logic that aligns with the current nature of state responsibilities. Bruce Vladeck, who ran the Medicaid and Medicare programs from 1993 to 1997, notes that the big growth areas in the Medicaid program in the 1990s "were in services for the mentally ill, the retarded and AIDS patients. Historically, the states did take care of a lot of those problems on their own."

But many of the efforts have been somewhat less aligned. States are allowed to claim certain health services delivered in schools as Medicaid expenses, for instance. But the accounting required to allocate the appropriate amount of overhead dollars to these legitimately covered areas can be just fuzzy enough to allow some fiscal finagling. In Massachusetts, the Office of the Inspector General for the U.S. Department of Health and Human Services discovered that about $4.9 million was being unreasonably charged to the feds.

There are also a variety of complicated but legal financing arrangements that states have used to attract additional federal matching dollars. One approach goes like this: States increase payment rates to nursing homes. The federal government reimburses the state for the higher amounts. The states then impose a tax on the nursing homes to recover the cost of the rate increase. The revenue goes into the general fund to be used however the state wants. The federal government has cracked down on this legal loophole, claiming that unchecked schemes like these could cost the federal government $5.8 billion over five years. But as quickly as one mechanism for siphoning federal dollars has been squashed, another seems to take its place.

Coverage versus Costs

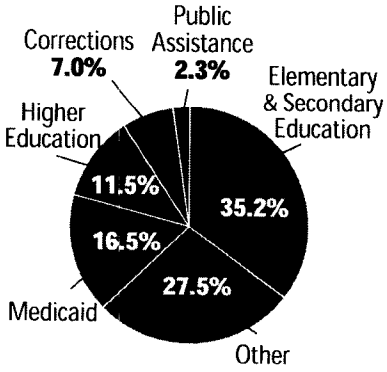
FY 2005



Source: National Association of State Budget Officers

Budgeting Their Own Money

State general fund spending by category, FY 2004



Source: National Association of State Budget Officers

At the same time, the federal government has become steadily less supportive of states' efforts to manage their programs well. One small way that the federal government could help states would be for it to identify a way to measure the cost efficiency per Medicaid beneficiary for each eligibility class, says Arizona Medicaid director Anthony Rodgers. "If I saw that some states were doing much better than us for the same type of beneficiary, I could go to those states and see what they're doing."

Many of the states have been unable or unwilling to take up the slack—or don't have the administrative resources. "Neither the feds nor the states have invested in running these programs well," says Schneider.

Perhaps the biggest bone of contention is over waivers—the exemptions from established law that the states need in order to experiment with their Medicaid programs. Waivers can take years to win approval from CMS. But even more to the point, advocates for Medicaid beneficiaries are concerned that waivers may not effectively balance cost savings with the need to retain quality and access. For example, they may include limits on the number of people served, which can result in long waiting lists for valuable services.

Meanwhile, governors complain that for some ideas that have already been tested, there shouldn't be a requirement to get a waiver from federal rules. For instance, states are still required to get waivers to provide long-term care in home- or community-based settings as an alternative to a nursing home. The rule persists, even though a million people already get their care this way and federal officials say they believe home and community care hold the potential for great success.

There is, of course, little patience in most circles for inefficient bureaucracy. When it happens in, say, a department of motor vehicles, the fallout—citizen rage over long lines or interminable waits—can be felt immediately in the governor's mansion and legislators' offices. But at least DMV inefficiencies only cost valuable time. When Medicaid doesn't work as well as it can—and when fiscal constraints keep care from the needy—people can die. If ever there were a state program crying out for close consideration and remodeling—not just to tame costs but to improve service—this is the one.

—Rebecca Adams

The States at Work—A report on reforms being road-tested in the states

Medicaid's Third Rail

Long-term care is shockingly expensive and politically hot to handle

"This is the biggest of the big issues in Medicaid," says James Tallon. The chairman of the Kaiser Commission on Medicaid and the Uninsured is referring to long-term care and all the issues, both fiscal and medical, that revolve around providing care and protection for the impoverished elderly and chronically disabled.

It's a lopsided problem. Long-term care devours one-third of all Medicaid spending, but it serves fewer than 10 percent of Medicaid beneficiaries. It is expensive—and getting more so. People are living longer, thanks in part to new medications and technologies.

But the older the elderly get, the more likely it is that they will eventually no longer be able to care for themselves or have access to support from family members. One spouse is likely to outlive the other by many years, and children have long since received their own memberships in AARP. Most private health insurance plans, as well as Medicare, may pay for short stays in nursing facilities or access to home health care but only under limited circumstances. For people who require extended long-term care, the staggering costs—an average of $52,000 a year—can quickly eat through any savings or income. Only when that happens is Medicaid called in to pick up the bill.

The tab is not just for ailing seniors. With more than 3.5 million Americans suffering from disabling chronic conditions, severe mental illness or developmental disabilities that necessitate long-term care, 37 percent of those receiving Medicaid long-term care benefits are under age 65 and account for 43 percent of Medicaid long-term care funding.

Healthy Home

When Medicaid first undertook to cover long-term care in 1967, nursing homes were pretty much the only game in town. That explains in part why these institutions are the only type of long-term care guaranteed by federal statute to Medicaid beneficiaries. But the world has moved on, and the use of home- and community-based care is expanding rapidly. In 2004, Medicaid spent about $31.7 billion on home- and community-based services, while nursing homes consumed $45.8 billion that year.

Home- and community-based care has humanitarian advantages, but one big question is whether it saves money. Most of the evidence seems to suggest it can. As Medicaid programs triage the most functional patients into programs offering lower-level supports, they can keep much of the caseload away from expensive institutions.

But as states get better at offering sophisticated services in the new, care-anywhere model, costs—and patient demands—are climbing. In Vermont, the average cost of a community-care slot has increased from half the cost of nursing home care six years ago to 80 percent of that cost now. Joshua Slen, director of the Office of Vermont Health Access, believes the cost increase reflects a steadily rising capacity to handle more complex and costly cases in the community. He admits that looming ahead is the question of what to do when an individual can be cared for in the community but at greater cost than in a nursing home.

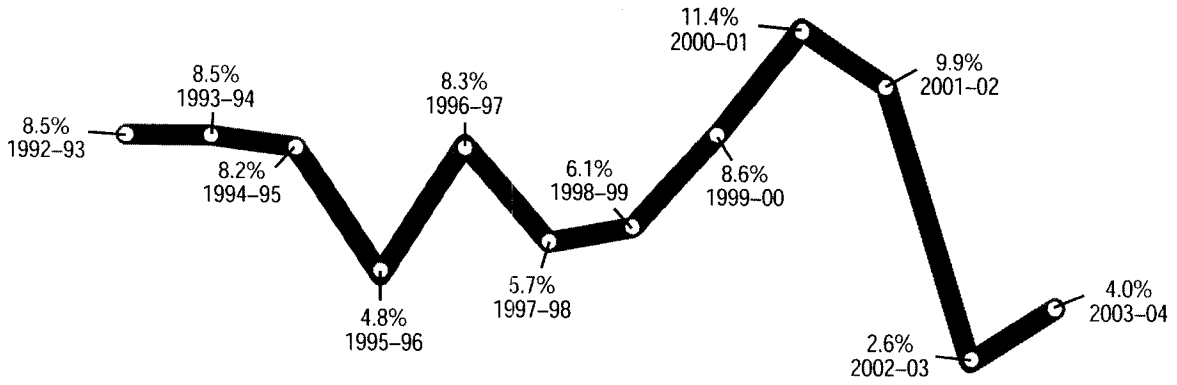
What's more, expenses may be driven up by the so-called "woodwork effect." Many Medicaid beneficiaries need help with daily living—dressing, bathing and the like—but don't apply to Medicaid out of fear that institutionalization is the only option. As a result, there is concern that as home care becomes widely available, these folks will come forward and overwhelm long-term care resources, to say nothing of budgets.

Fortunately, states have ways to control this unaffordable outcome, and as a result it hasn't become as big a problem as some predicted. They use financial eligibility restrictions, waiting lists, functional requirements and measured deployment of services to balance service provision with available funds.

The tricky part is to make sure that people get the service option that is right for them and cost effective as well. Unfortunately, program caps result in waiting lists, and some in-

Growth Center

Annual percentage change in Medicaid expenditures for long-term-care services, 1992–2004



Source: Centers for Medicare & Medicaid Services

dividuals on a list for less expensive services may be forced to accept a place in a nursing home, the more expensive option.

Vermont recently won federal approval for a demonstration program in which the long-term care eligible are divided into three groups. Those who have the highest needs are entitled to either facility- or home-based care. Individuals with high needs or moderate needs are served next with the money that is available. With total Medicaid funds in this project capped, individuals with lesser needs may have to wait, but the state knows that those with the highest needs will be served first in whatever setting is right for them.

In Texas and a number of other states, some individuals who are in nursing homes can bypass waiting lists for home and community services. Since there is an immediate cost saving by returning them to a community setting, they are granted immediate access.

Connecticut, which launched home- and community-based care for the frail elderly in 1987, reports that it took a while, but actual cost savings eventually showed up. By 2000, "we were seeing an impact that we could attribute to the home- and community-based services option, even though we could see an increase in the use of services from those options," says David Parella, director of the state's Medical Care Administration.

A Business Proposition

It should come as no surprise that there's at least one group resisting the move to home- and community-based care: nursing homes that fear they will inevitably lose business. Based on that assumption, the nursing home industry in many states has hired effective state-level lobbyists to oppose large-scale shifts in funding and policy.

This scenario plays out differently in each state, but in Ohio, legislative protections ensured automatic rate increases for nursing homes. This meant that even when there were fewer Medicaid patients, nursing homes could charge ever-growing amounts to the program. There was a change of heart this year, however. With budget shortfalls looming large, the state legislature shifted the reimbursement system toward a less generous model that should result in lower payments.

Other answers are emerging for keeping the supply of nursing home beds at appropriate levels. Alaska, Florida, North Carolina and a number of other states have implemented certificate-of-need requirements before new beds can be added at any institution.

Georgia and other states have implemented acuity-based payment systems whereby Medicaid reimburses institutions at variable rates based on the patient's condition. "If a nursing home has easy patients, where everyone is walking around and going to singing therapy, they're going to get less money now," says Georgia Medicaid director Mark Trail. "If you have people who are bedridden or have dementia, you'll get a higher payment." The program is cost-neutral in that it shifts payment levels among institutions. Trail estimates that occupancy has gone down statewide by about 5 percent as a result of the payment change.

In some states, Medicaid officials are focused on working with the nursing home industry to adapt to the shifts in demand. New Mexico, for instance, has been getting nursing homes to add adult day care to the mix of services they provide.

Personal Control

One strategy to retain quality and access has received a great deal of attention, although the jury is out on whether it will help cut costs as well. Consumer-directed care gives beneficiaries an allowance based on their level of need. The beneficiaries can then hire whomever they choose—relatives, neighbors, friends—to provide personal care services. They can also use the funds for approved purchases that enhance their ability to live safely at home, such as a wheelchair ramp or even a microwave oven. A demonstration project, tested in Arkansas, Florida and New Jersey, won high

Heading Home

Distribution of Medicaid spending on nursing facilities versus home health & personal care, FY 2004

STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE	STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE	STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE
Ala.	63.6%	29.9%	La.	44.1%	23.9%	Ohio	53.8%	21.9%
Alaska	35.9	58.9	Maine	32.4	54.5	Okla.	45.0	37.2
Ariz.	46.7	36.9	Md.	51.3	34.1	Ore.	25.0	71.2
Ark.	56.0	24.6	Mass.	48.2	43.4	Pa.	65.2	24.4
Calif.	30.4	42.6	Mich.	77.7	20.5	R.I.	53.4	42.5
Colo.	44.3	50.6	Minn.	33.9	57.7	S.C.	44.3	35.0
Conn.	49.0	38.3	Miss.	61.5	14.8	S.D.	53.6	36.8
Del.	55.6	28.3	Mo.	46.2	37.3	Tenn.	61.9	23.7
Fla.	59.0	32.6	Mont.	55.4	38.1	Texas	36.3	45.1
Ga.	56.6	36.6	Neb.	52.9	33.5	Utah	33.4	46.3
Hawaii	61.1	36.4	Nev.	47.5	32.0	Vt.	39.6	60.0
Idaho	38.5	40.8	N.H.	60.3	38.5	Va.	42.1	27.4
Ill.	47.7	26.9	N.J.	47.6	30.7	Wash.	34.7	55.1
Ind.	46.7	24.7	N.M.	29.5	66.7	W.Va.	50.0	38.0
Iowa	42.5	32.4	N.Y.	37.6	43.8	Wis.	46.9	40.1
Kan.	37.3	53.0	N.C.	41.0	41.6	Wyo.	34.2	50.8
Ky.	54.3	31.7	N.D.	56.2	23.9			

Notes: The balance of LTC spending in each state is on mental health facilities and services. Arizona's figures are based on nationwide patterns and do not reflect the actual spending distribution in that state.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates from Centers for Medicare & Medicaid Services data

participant-satisfaction rates and improved access to quality care. In Arkansas, for instance, the state realized a 29 percent increase in the number of beneficiaries who were very satisfied with their care and a 58 percent drop in beneficiary-reported abuse. As with other long-term-care options, monitoring is required to ensure quality. To enhance its remote oversight, Arkansas is developing a telephone system through which service providers will "clock in" when on the job.

Early feedback on cost factors has been inconclusive. A Mathematica Policy Research study found that in Arkansas the consumer-directed care program cost more than traditional care. The study attributed most of the difference to higher utilization of benefits but found that the gap dropped to statistical insignificance in the program's second year. Meanwhile, 12 other states are developing consumer-directed care programs.

The approach helps resolve another long-term-care issue: shortages of personal care providers. By allowing beneficiaries to pay friends and family for care, the program can capitalize on an otherwise untapped pool of labor.

Another emerging approach for home and community-based services is managed care. Pioneered by Arizona, the strategy creates a strong incentive to take advantage of the cost-saving potential of localized services. With 61 percent of the long-term-care population served at home and in the community, Arizona officials claim low costs per beneficiary. The state also spends only 27 percent of its Medicaid bill on long-term care, compared with the nationwide average of 32 percent. Florida is developing a comprehensive managed care program that would integrate acute and long-term care for people over 60. And a number of states are expanding managed care for the under-65 disabled population.

The Take Back

When an elderly person qualifies for Medicaid payment for long-term care, he or she presumably has used up all but a few personal assets and is now impoverished. The reality is that there are a number of ways to fake poverty, notably by transferring assets to children or grandchildren. The Medicaid program discourages such asset manipulation by using a three-year "look-back" to review an applicant's financial situation. Efforts are also made to clamp down on banking loopholes that help people shield their money.

But staying ahead of seniors and the attorneys who serve them is no easy task. Medicaid finds itself playing catch-up to a large community committed to hanging on to their savings, even when that means other taxpayers must take up the slack.

The federal Medicaid Commission has proposed ways to tighten or close some of the existing loopholes, such as extending the look-back period. Many state officials would like to see the federal government set new requirements. "At the state level, we get lobbied every time we try to close loopholes," says Arkansas Medicaid director Roy Jeffus. "We can't get anything through." He estimates that about 5 percent of the Medicaid long-term-care population may be taking advantage of the loopholes.

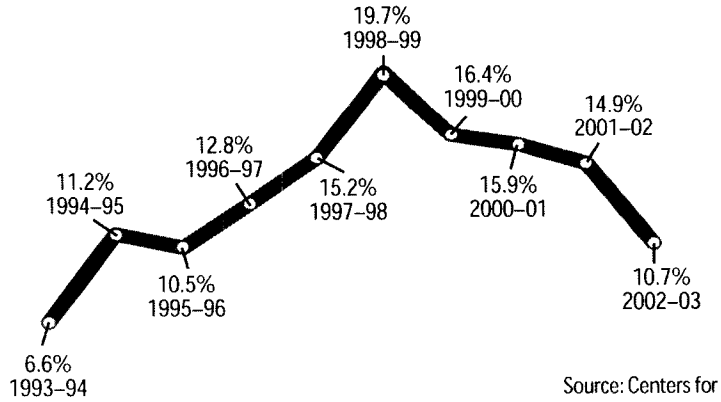
In addition to liquid assets, a number of states are concerned about recovering homes that are exempt from eligibility limits during a beneficiary's lifetime. For them, there is something deeply troubling about a Medicaid beneficiary staying in a nursing home for free for 10 years and then leaving a $250,000 house to her kids. On the other hand, some have noted the irony of eliminating the inheritance tax for the very wealthy even as inheritance collections get tough at the other end of the spectrum.

In 1993, Congress mandated that states implement estate recovery programs to go after orphaned assets, but many states declined to pursue this tack aggressively. Voter support for snatching the family home away from impoverished elderly—even those no longer using the home—was less than enthusiastic. When the 2001 recession came along and states were in deepening fiscal distress, however, many states had to choose between active estate recovery or deep cuts in services. Some ratcheted up their pursuit of the estates of those permanently ensconced in an institution or deceased.

Georgia began doing estate recovery last year, and the first year of effort has been fruitful, reports Mark Trail. "People are less likely to put grandma in a nursing home if they know the family farm is on the line," he says. The state has seen a drop in nursing home occupancy and a spike in home- and commu-

Pill Bill

Annual percentage change in national spending on prescription drugs, 1993-2003



Source: Centers for Medicare & Medicaid Services

nity-based participation, which Trail believes are linked to the estate recovery effort.

Assets on the Line

Observers of the Medicaid program have long insisted that the free market should be able to buffer some of the costs associated with long-term care, and a focal point has been long-term-care insurance. Many insurance products on the market today are, however, expensive, prone to unexpected premium increases, void if allowed to lapse, inapplicable before the age of 65 and ineffectual at protecting the full extent of a policyholder's assets. In addition, premiums often increase dramatically as individuals age, so people drop their policies just when they need them most.

Still, many observers believe that the quality of the insurance can be improved. If the policies are fairly formulated, they have potential to discourage middle-class and higher-income seniors from spending down assets to qualify for Medicaid.

One federal-state insurance program that has won plaudits is the Partnership for Long-Term Care, a demonstration program initiated in 1988 in California, Connecticut, Indiana and New York. Under this program, individuals purchase a qualifying long-term-care insurance plan, and if they exhaust its benefits, they receive protection of their assets up to the amount payable under the plan, in addition to that provided under normal Medicaid eligibility rules.

In 1993, the U.S. Congress, concerned that the Partnership would shunt benefits disproportionately to the wealthy, passed a law preventing other states from implementing similar programs. But there is support for an extension of the program nationwide, and it comes from the National Governors Association, as well as the 17 states that have passed enabling legislation in case of a congressional reversal. Preventing federal officials "from approving additional partnerships like ours was a mistake," Connecticut's Parella says. "With the baby boom generation coming into that period of time where they're looking at long-term care, they should be encouraged to do everything they can."

Pushing for personal responsibility among the boomers, several states also are supporting tax incentives for long-term-care insurance. Consumer tax credits for insurance purchases, inclusion of long-term-care insurance under health spending account guidelines and tax credits for employers who pay toward qualifying policies have been put forward as means to encourage middle-class and affluent individuals to purchase this type of coverage. Critics argue that such credits will not heat up the private insurance market enough to justify the tax revenues lost.

While these proposals certainly hold out much hope, in the morbid calculus of long-term care, the same factors that allow so many people to enjoy longer lives translate into increased costs and distressed budgets for families, states and the federal government. Despite the best efforts of so many minds, true long-term solutions are elusive.

—Jenny Mandel

The Rx Factor

States have put the brakes on prescription drug costs, but Medicare may be their undoing.

It was nothing to catch a Medicaid director's eye: In 1990, prescription drugs ran up a Medicaid bill of $4.4 billion—5 percent of the program's overall expenditures.

Bells were in full alarm by 2003: The tab had climbed to $26.6 billion—11 percent of expenditures. Medicaid programs in every state began taking cost-cutting measures. And they've had significant success. Prescription drug costs are no longer growing at the alarming rates experienced between 1997 and 2003. There are no hard statistics to back up the dramatic slowdown—national figures only go up to 2003—but based on interviews with dozens of states, it is clear Medicaid programs across the country have significantly diminished the rate of growth.

In crafting strategies, states found that a critical issue was to keep costs affordable while making sure the benefits of new (and

Although there are risks, preferred drug lists have tamed costs and improved prescribing patterns and quality of care.

often high-priced) medications were still available. Over the past 15 years, more than 300 new drugs, biologics or vaccines have been approved by the U.S. Food and Drug Administration, and many of these new medications are not only life-saving but ultimately cost-effective as well. Since protease inhibitor drugs were launched in the 1990s, for example, the U.S. death rate from HIV/AIDS has dropped by 80 percent. Of course, that remarkable outcome has led to more prescriptions. But treatment costs have gone down. Among Medicaid's HIV patients, there's been a 43 percent drop in inpatient hospital care since protease became widely available. That translates into cost savings of between $16,000 and $24,000 a year per patient.

Michael Ditmore, director of the Division of Medical Services in Missouri, shared some statistics that help put the underlying cause for growth in prescription costs in perspective: The number of prescriptions written in Missouri soared by 44 percent between 2001 and 2005, but the cost of prescriptions grew by only 29 percent over the same period. As new medications are developed that genuinely improve quality of life, the name of the game is to keep costs of each medication as low as possible.

Making a List

One powerful cost-saving tool has been the preferred drug list (PDL). The idea is simple. Once a board of experts determines that several drugs in a therapeutic class are equivalent in their effectiveness, states negotiate with pharmaceutical manufacturers over prices and rebates. The medicine with the best price is added to the preferred list, while the other equivalent products must go through a prior authorization process—the doctor has to ask for approval to prescribe the medication.

California pioneered PDLs in the early 1990s. Drug manufacturers must negotiate on price with the state or risk losing access to its pool of 8.5 million beneficiaries. Similarly, Florida, another big state and early adopter, has enjoyed healthy savings with its PDL: almost $500 million between 2000 and 2002 for its 2.2 million Medicaid enrollees. Tom Arnold, Florida's deputy secretary of Medicaid, takes advantage of his state's size during discussions with drug manufacturers. "Do you think drug plans are going to pull out of a 2.2 million person market?" he says. "We have the buying power and market power, unlike the commercial marketplace."

Even smaller states have had remarkable success. West Virginia, which implemented its PDL in the middle of 2003, experienced zero growth in pharmacy expenditures in 2004. It helps that the provider compliance rate runs upwards of 95 percent. The state won't be able to sustain zero growth, but it's highly likely that it won't soon hit its prior annual 16 percent rate of growth.

Nearly 40 states now either operate or are in the process of implementing a PDL, but the pharmaceutical industry hasn't gone along willingly. The Oregon legislature was persuaded by a "strong pharmaceutical lobby" to reject a measure to require prior authorization for drugs not on its PDL, according to Lynn Read of Oregon's medical assistance office. Similar pressure in South Carolina defeated a bill to mandate a PDL for Medicaid, says Robert Kerr, director of the state's Department of Health and Human Services.

Of course, powerful cost-saving tools such as PDLs have risks, too. Some states have been accused of keeping drugs off their lists simply because of their cost—without sufficient regard to their medical benefits. By contrast, even though the Oregon plan may not be the most fiscally effective, it has been hailed by a cross-section of stakeholders for the powerful clinical evaluations it uses before keeping any drug off the list.

In states that have PDLs, Medicaid directors say the lists have not just tamed costs but also provided other benefits. "We've improved the prescribing patterns of the providers, and the quality of care," says Nancy Atkins, West Virginia's Medicaid director. Preferred drug lists have also proved to be an effective way to drive physicians to prescribe generic drugs, which are much less costly than brand-name medications.

The price competitiveness of generics has had other consequences. Manufacturers of brand-name drugs will sometimes offer states a lower price than the generic manufacturers in order to gain access to the PDL.

A Little Togetherness

The strength of preferred drug lists lies in a notion long familiar to any retailer: "The

$13 million
Savings on prescription drugs Michigan's Medicaid program experienced in 2004 by buying through a multi-state purchasing pool

power of the big pencil." But even states that don't have the enormous buying power of a California or New York can put together a big pencil in a variety of ways.

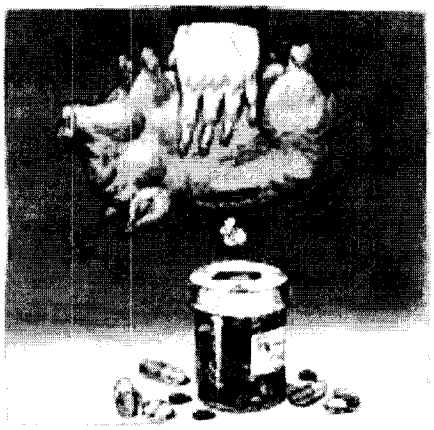
One is "intra-state" pooling, where a state will negotiate manufacturer discounts and manage the prescription drug benefit for multiple programs, such as the state employee health plan, the Medicaid program and university health plans. Georgia estimates that its intra-state pooling resulted in savings of $60 million between October 2000 and January 2003.

Several states have looked to interstate efforts. In 2003, Michigan and Vermont created the first multi-state pool, called the National Medicaid Pooling Initiative. Twenty-six manufacturers submitted price proposals. For Vermont, a state with approximately 50,000 fee-for-service Medicaid beneficiaries, the benefits from cooperating with Michigan and its 500,000 fee-for-service enrollees were clear. More than twice the number of manufacturers participated in Vermont's PDL in 2003 than had previously been involved.

In 2004, Alaska, Nevada and New Hampshire signed on. This time, the larger pool generated price discount proposals from 40 manufacturers. According to Paul Reinhart, director of Michigan's Medical Services Administration, his state saved $13 million in 2004 by purchasing through the pool.

Savings should increase as more states join. In 2005, the pool added four more states—Hawaii, Minnesota, Montana and Tennessee—and Kentucky has submitted an application to join. Meanwhile, Vermont has left the original pool to form a new one with Iowa, Maine and Utah. Today, the National Medicaid Pooling Initiative represents 3.8 million individuals and wields $5 billion in purchasing power.

Some health officials worry that further squeezes on the pharmacy tab could be counterproductive. "At this point," says Janet Olszewski, director of the Michigan Department of Community Health, "you would have to worry that any additional changes could harm care."



Tiny Squeezes

One technique, which seemed to be gaining popularity a few years ago, is going out of favor today: limits on the number of prescriptions per beneficiary. This kind of one-size-fits-all approach is seen as a threat to people's health, even if there are ways to soften the limits in individual cases. "Several years ago, we were looking at a seven-prescription limit," says Michael Deily, director of Utah's Division of Health Care Financing. "But that limit went over with our population like a lead balloon." Today, Utah has taken a different tack. Through a contract with the University of Utah School of Pharmacy, it looks at the people with multiple prescriptions to figure out the reason for such high numbers. "We found multiple prescribers who didn't know the other existed and also found errors," says Deily. "This specific effort is saving the program about $3.5 million."

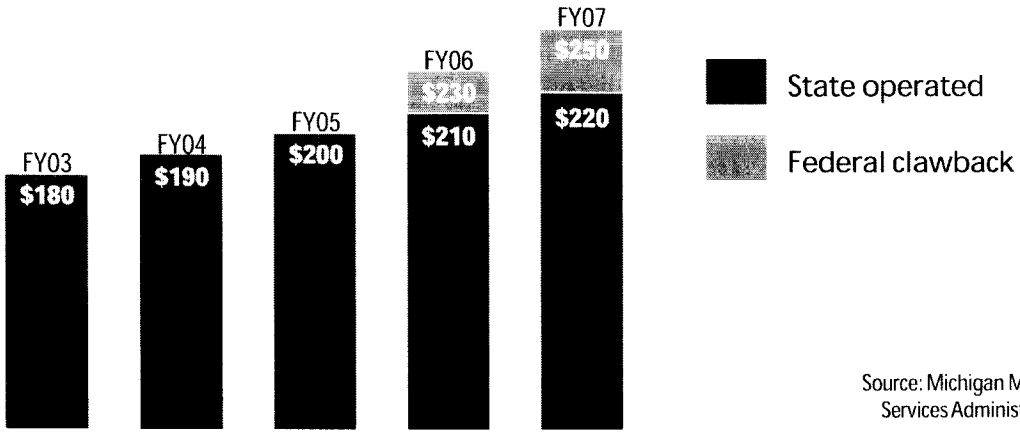
There are several other ideas making the rounds, but they're pretty much untested for the moment. For example, the federal Medicaid Commission suggests basing pharmaceutical prices on Average Manufacturer Price rather than published Average Wholesale Price as is done today. Since the manufacturer price is lower than the wholesale price, the federal Centers for Medicare & Medicaid Services estimates savings from that approach of $4.3 billion over the next five years.

State Medicaid directors think this number is overly optimistic. In any event, they believe there are real problems with both benchmarks and that changing from one to the other won't help. Many are skeptical about using an average that is based exclusively on drug company calculations.

States are more hopeful about saving money through limits on dispensing-fee payments to

The Giveaway

The impact of federal "clawback" on Michigan's costs when Medicare takes over prescription drugs for dual eligibles (in millions)



Source: Michigan Medical Services Administration

pharmacies. The amount paid for distributing and dispensing drugs accounts for 23 percent of Medicaid pharmaceutical expenditures. Bypassing the pharmacy altogether offers promise. Maine, for instance, has demonstrated success with its mail order program. The state nets 9 percent every time it moves a prescription to the mail. Of course, there are potential tradeoffs here, as pharmacists can educate patients about medications, watch out for unpleasant interactions and monitor compliance.

700 Pounds of Gorilla

Many state officials are not so much concerned with creating new pharmacy savings as they are about retaining the tools that enabled those savings. Starting this year, the dual-eligible population—people entitled to Medicare who are poor enough to qualify for Medicaid as well—will receive their pharmacy benefit from Medicare. Historically, these individuals were covered for pharmacy by Medicaid, and their pills constituted roughly half of Medicaid's drug bill.

Without the dual eligibles in their bailiwick, states could find they have less leverage when negotiating price with pharmaceutical companies. That will hurt, but it won't be deadly. "Instead of the 800 pound gorilla we are today," says Florida's Arnold, "we'll be a 700 pound gorilla."

Loss of leverage is not the only issue states face. They may also lose access to vital data. Under the Medicare Prescription Drug Improvement and Modernization Act of 2003, prescription drug plans under Medicare are not required to share their data on the dual-eligible population with Medicaid programs. That, in turn, could weaken other important Medicaid programs, such as disease management and care-coordination efforts that rely heavily on such information.

Finally, the Medicare prescription drug bill may actually cost states money outright. A provision in the bill—often referred to as the clawback—requires states to return 90 percent of pharmacy costs to the federal government's Medicare program to compensate it for assuming the expense of those patients. But that's 90 percent of a total that was estimated using 2003 figures and the growth rates prevalent at that time—rates that were far higher than today's. So, the real progress in savings that states have made on medications in 2004 and 2005 are being clawed back, based on what states consider to be unrealistically high numbers. Some states estimate that they are going to fare much worse than they would have in a world in which the Medicare legislation never passed. For example, Ohio expects to come up $57 million short, New Mexico $18 million and Michigan $20 million. Some states are considering legal challenges on the grounds that they are being required to pay for a federal Medicare benefit over which they have no control. **—Misha Segal**

The Great eHealth Hope

Technology could be a painless cost cutter for the future, but who is willing to pay for it today?

An unhappy patient who speaks little English steps into a public health clinic mumbling about dizziness, nausea, diabetes and Medicaid. He shows the intake nurse a handful of different pills and a Medicaid card, then sits for hours in the waiting room while a translator is found. Unfortunately, he doesn't know what the pills are for, in any language. Numerous tests—some rather expensive—are necessary to fill in his blank record. Most of the results won't be in for days, and he heads home feeling no better than when he walked in. Medicaid is billed for the visit.

An alternate scenario: The same man with the same complaints steps into the same clinic with a tiny plastic card, which is used to call up his complete electronic health record. A physician reviews the record on a hand-held device and makes note of diabetes and heart disease. The doctor reviews the six medications the man is taking, noting that they were prescribed by three different specialists. In the examination room, the doctor surmises that the patient's symptoms are likely caused

Fly Me to the Moon

Making e-medical records a reality

In 2004, President George W. Bush called for electronic medical records to be available for most American within 10 years, and the U.S. Department of Health and Human Services has taken the lead to bring public and private entities to the table and forge consensus on how to move ahead with health information technology. The past year has seen a flood of proposed legislation calling for investment in eHealth initiatives. Several of these legislative approaches call on government to lead the way with the enormous buying power represented by Medicaid, Medicare, veterans' and other government health plans.

But one question being raised about that effort is the timetable. Why is HHS's time frame for wide-scale implementation—an implementation that would use technology we already have—the same as President John F. Kennedy's was for landing on the moon, using technology nobody had developed yet?

by a bad drug interaction. She checks her diagnosis against an evidence-based practice database, prescribes an alternate medication and alerts the original doctors. Upon entering the recommendations into her hand-held device, the clinic doctor selects "translate," and shows the man the resulting screen.

The reality of health care technology today is the first scenario. The average teenager plugs into more sophisticated technology to play Duckblasters online than many health care providers use to manage the critical care they provide. "From nearly anywhere in the world, we can withdraw money from our bank accounts, pay bills, apply for a mortgage, book airline tickets and even order groceries online," says Michael Leavitt, secretary of the U.S. Department of Health and Human Services. "But, more often than not, we can't share an X-ray digitally from one hospital to another, even if they are on opposing street corners."

The list of forgone advantages of technology is troubling: Simple innovations can streamline care, reduce duplicative tests and procedures, boost doctors' use of evidence-based practices, eliminate transcription and dispensing errors and simplify billing and reimbursement. And what would be good for the health care system would be very, very good for Medicaid.

It's not like the missing technology is the stuff of science fiction. Virtually all of it already exists and is used in various other disciplines. In fact, the Holy Grail—a fully modernized electronic health record (EHR)—could become a reality without any innovative technological advances. Estimates of cost savings vary, but in 2004, then-HHS Secretary Tommy Thompson estimated that nationwide adoption of EHR systems could save 10 percent of the country's annual health spending. With spending at $1.7 trillion a year, that's $170 billion annually. For Medicaid, a 10 percent annual savings would amount to a cost reduction of $33 billion per year. And these savings would likely be accompanied by better medical care, a greater capacity to deal with more home-based care, improved preventive care and wider use of disease management.

With political leaders from President George W. Bush to Senators Bill Frist and Hillary Rodham Clinton calling for EHR, and with the potential of a financial windfall from it, why is it taking so long to get health information technology moving? The simplest answer is sticker shock. A September 2005 study by Rand Corp. places the cost at $8 billion annually. Another fundamental obstacle is that the American health system consists of so many moving parts that getting all those entities aligned behind a single system is akin to making the dozen apocryphal clocks chime simultaneously.

Federal and state agencies, hospitals, HMOs, private providers, pharmacies and private insurers all have their own mix of technological tools and paper-based systems, developed over years of operation. But this has been a flawed evolution: The technologies can't be used in a uniform, interactive way. What's true of the health care system in general is reflected in Medicaid as well. States are riddled with systems that are unable to communicate with one another. Joshua Slen, director of Vermont's Medicaid program, has found that communication among all the interested parties is one of the biggest challenges to moving forward. "We're blessed that Vermont is a small state," he says. "But IT is complicated even for us where we can get the 100 people who make the decisions in a room together."

Action Figures

Although a nationwide EHR program lies in the future, individual state Medicaid programs are making some health IT progress right now. For the moment, the federal government provides a match of 75 to 90 percent on most Medicaid IT infrastructure investments and that has allowed many states to improve their existing Medicaid Management Information Systems (MMIS). About half the states are revamping their systems. The state of Washington, for instance, is upgrading its 30-year-old technology, and that raises the question of why it has taken a state that is often ahead of the curve on technology so long to revamp a basic system like MMIS. "Even though it's 90 percent paid for by the federal government, you still have to pony up 10 percent," says Doug Porter, who works with the Medicaid program. "If it's a $150 million system, there are probably 10 initiatives where the legislature would rather spend the $15 million."

Some states say they are forced into revamping, regardless of cost, because their systems are too out of date to maintain. In Ohio,

$33 billion
Estimated amount of money Medicaid could save annually with a fully modernized electronic health record.

Medicaid officials are about to redo their 20-year-old medical records system. It is written in a programming language that is now obsolete, and the state can no longer find programmers to maintain the program.

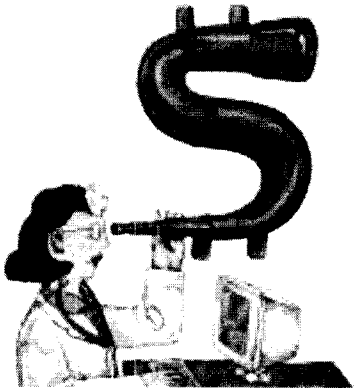
Some states are spending money on IT innovations in segments of their Medicaid systems. Utah is investing in a statewide electronic immunization registry that allows physicians and health departments to cross-check the same database. Wisconsin has updated its MMIS to be Web-based, with 90 percent of claims submission and real-time adjudication of pharmacy claims online, for a saving in administrative costs of $90 million over five years.

Des Varady, CEO of Portland, Maine-based Health Watch Technologies, says the first step toward many innovations is simply tidying up systems for data warehousing, third-party billing, utilization review and other aspects of Medicaid management. Some states, he observes, have excellent data, which means they can get electronic services up and running in little time. Others still need to groom and process the data they have—something that could take many months—to get services off the ground.

eScrip Writers

A number of states have been using technology to better manage the use of prescriptions. In Florida, a three-year old program is focusing on this area. Since about 80 percent of state Medicaid prescriptions originate with 20 percent of the physician pool, the state looked at ways it could help those high-volume doctors manage their prescription records more effectively.

The ensuing program equips high-prescribing doctors with handheld devices that provide them with real-time data on the medication history of each of their patients. The state sent letters to the target physicians inviting them to participate in the program. Those who signed up received a palm device that op-



erates on standard cell-phone networks, with specially designed software to manage prescription records. In the first phase of the program, the device acted as a reference tool, with a patient's identification number calling up a 100-day record of one-time and recurring prescriptions. Armed with this information, physicians could make informed decisions about additional medication.

The results of this phase were heartening. Severe drug interactions dropped from 7 to 4 percent of the 1.7 million beneficiaries covered by the system, and there was a clear reduction in the number of pharmacy claims and prescriptions. The systems, including the devices and physician training on them, cost $2,100 per doctor in the first year and $1,700 each year thereafter.

The program expanded in its second year to provide full e-prescribing. When a doctor enters a new prescription, he receives an immediate confirmation of whether Medicaid covers the medication. The prescription is conveyed to a pharmacy of the patient's choice, eliminating confusion over illegible handwriting or lost paper prescriptions, and the patient can pick up the prescription at his convenience.

The device is simple to operate, works anywhere a cell phone would and eliminates that phase of an exam in which the doctor must figure out a patient's drug regimen from a combination of charts and the patient's sometimes sketchy recall. Also, if the physician sees from a patient's record that drug abuse may be taking place—too many prescriptions for a single medication, for example—the doctor can flag the record for state review. Net savings for two years: about $50 million.

Digging Deep

Data mining is a hot buzzword in health IT, and the concept is pretty simple: Glean useful information from data already in hand and use it to improve the system.

One potent example comes from Rhode Island. A drug utilization review board was discussing whether balance problems that lead to many elderly people falling and winding up in

States are using technology to better serve pregnant women in rural areas and help prevent seniors from falling—saving money in the process.

hospitals might be caused by the medications they are taking. The state mined its database of Medicaid, Medicare, veterans' and hospital records and found that among those who were 80 years of age or older—40 percent of whom suffer falls that lead to hospitalization—many were taking medications deemed "high risk" for causing dizziness and drowsiness.

From data that were already being collected, the state identified 7,200 patients who were at high risk for falls. In total, they were seeing 1,400 doctors. Letters were sent out to those doctors highlighting the problem and listing the full medication regimens for each of the vulnerable patients in their care.

The letter-writing campaign, backed by the state's hard data, led to an 8.5 percent decrease in the number of people taking four or more medications, for drug savings of about $350,000. The state has not completed a formal assessment of the campaign's effects on falls and nursing home admissions but expects to see a lower admission rate. That's helpful to Medicaid's bottom line. "Some of the monetary value is immeasurable, too," says Frank Spinelli, administrator of Rhode Island's Center for Adult Health. "If you're mailing letters about a best practice, other patients will benefit."

Phoning It In

In Arkansas, one technology focus has been on ensuring that pregnant women who are considered high risk have access to specialized medical care, even if they live in a rural area far from a major hospital.

At the core of the program are telemedicine and video-conferencing, which are put to use by Arkansas's specialized fetal medicine center located in Little Rock. The hospital has a tele-consultation program that "sees" about 50 Medicaid patients per week. In a three-way hook-up, a conference might include a genetic counselor based in Fayetteville, a fetal medicine specialist in Little Rock and the patient and her doctor in a local examining room. The specialists can remotely operate an ultrasound to examine the patient. When the time comes for delivery, the pregnant woman is transported to Little Rock.

Improved birth outcomes have resulted in $17 million in savings annually to the Medicaid program. These savings come not only from reductions in the length of newborns' stays in pricey intensive care settings but also from a diminution in the need for home health care, which is usually required by neurologically traumatized newborns, and reductions in subsequent long-term care.

—Jenny Mandel

Something of Value

Will cost sharing make Medicaid patients better health care consumers or sicker ones?

Medicaid has long been wary of asking beneficiaries to share the costs of their care. For most recipients, the program has not permitted premiums or anything beyond very minimal co-payments for a limited number of services. But that's likely to change—and soon. Medicaid officials at both the state and federal levels argue that the free ride is as outmoded in medicine as the house call.

For a model on cost sharing, many are looking at the State Children's Health Insurance Program (SCHIP), which covers young people with somewhat higher family incomes than those who receive traditional Medicaid benefits. There, states have more leeway to impose charges and participants with incomes above 150 percent of the federal poverty line can be asked to pay a cost-share of up to 5 percent of family income. The preliminary report on Medicaid reform from the National Governors Association (NGA) calls for Medicaid to follow SCHIP and to allow cost sharing but with a 5 percent cap for all beneficiaries, which the NGA considered "a critical balance to this proposal."

That's not the only cost-sharing suggestion out there. The federal Medicaid Commission would like to give states flexibility to increase co-payments on non-preferred drugs above the current nominal maximum of $3 per prescription—to enourage "cost-effective utilization." The Centers for Medicare &

"You have to have some economic tension—people have to have some skin in the game."

TENNESSEE GOVERNOR PHIL BREDESEN ON COST SHARING FOR MEDICAID PATIENTS

Medicaid Services estimates that $2 billion could be saved over the next five years if states were allowed to increase their caps in a variety of ways.

Out in the states, these proposals find sympathetic ears. Many state officials—Medicaid directors among them—deem co-payments, deductibles and premiums entirely appropriate in a time when nearly all Americans are expected to pay something for each physician visit or prescription. They argue that a lack of financial accountability encourages beneficiaries to use medical care when it's not necessary.

"You have to have some economic tension—people have to have some skin in the game," says Tennessee Governor Phil Bredesen. He adds that it's not enough to dismiss co-payments on the basis of poverty since most other services ask for some payment by the poor. "At faith-based clinics," he points out, "they take it as an article of faith that everyone has to pay something for the service—that what you get for free, you don't value."

Bredesen's argument appeals to the American ideal of self-sufficiency, and it is a cornerstone of the NGA report. "The purpose of increased cost-sharing is not to restrict access to necessary medical care," it states, "but to allow individuals to contribute to the costs of their own health care as much as possible. These new policies would be monitored and evaluated heavily, and if the evidence shows that increased cost sharing harms appropriate access, the policies should be revised."

Check Out the Evidence

Currently, most state officials have difficulty producing hard data to prove claims that this technique will instill personal responsibility in Medicaid beneficiaries and thus save money. In fact, some observers argue that co-payments, deductibles and similar requirements may result in clients' failing to access services or dropping coverage altogether. Preventive care, which can easily be delayed or ignored, may well be the first casualty. This ultimately can endanger the health of medically needy citizens and eventually generate higher costs in the system.

Washington State's governor, Christine Gregoire, is particularly concerned about preventive care and has emphasized the importance of getting coverage for all the eligible children in her state. So, when Washington received federal approval to impose a $10 monthly premium for families at 150 to 200 percent of poverty, she suspended that particular plan.

One factor that makes the debate over cost sharing so complicated is that the Medicaid population is not homogeneous. According to Chuck Duarte, administrator of the Nevada Division of Health Care Financing and Policy, co-payments and other charges work "for higher-income populations, who are more used to insurance products that use cost sharing. But for the aged and disabled population, with multiple prescriptions and frequent physician services, cost sharing is not going to be an effective tool. These people already have a hard time paying for whatever they have to pay for to stay alive."

A few years ago, Vermont imposed premiums on higher-income groups in its Medicaid and SCHIP programs. Forty thousand people were hit with the premiums in December 2003. The following month, 11 percent of those clients were disenrolled for nonpayment of premiums. However, just a month later, about one-third of the disenrolled paid their way back into the program. Vermont officials say they generally have seen this pattern when they increase cost-sharing requirements.

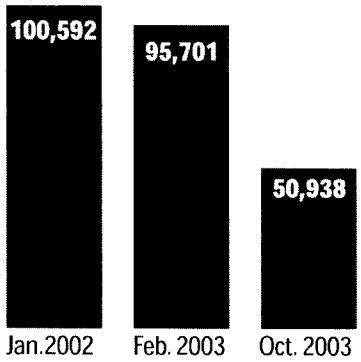
Joshua Slen, director of Medicaid in Vermont, is not alarmed about the drop-off in Medicaid rolls. Slen—and a number of others—believe that those who stay out of Medicaid after premiums are increased are a generally healthier group than those who stay in the program. "If you look at the program," he says, "it's clear that the people with higher levels of need continue to pay the premium."

The Oregon Case

Medicaid-eligibles in the entitlement portion of the Oregon Health Plan are not required to pay premiums or co-payments. But a federal waiver in early 2003 allowed the state to tighten up on other Medicaid beneficiaries. This group falls under the Oregon Health Plan Standard (OHP Standard) portion of the Medicaid program where state officials increased the premiums to a range of $6 to $20 a month based on income and also

The Fallout Factor

Oregon Health Plan Standard enrollment, before and after premiums and co-payments were added



Source: Kaiser Commission on Medicaid and the Uninsured

tightened rules on nonpayment. They lifted exemptions from the premiums for such "hardship" groups as the homeless and imposed stricter payment deadlines that, if unmet, resulted in an immediate loss of Medicaid eligibility for six months. In addition, many adults covered under OHP Standard were subject to co-payments of $3 to $250 for most covered services.

Shortly after these changes were imposed, enrollment in OHP Standard dropped significantly—from 95,000 in February 2003 to just over 50,000 by the end of the year. At the lowest income level, 59 percent of beneficiaries with no incomes lost their Medicaid coverage after being required to pay a $6 monthly premium.

"While it is difficult to do a cause-and-effect because so many other changes were going on at the time, this was the most salient factor in the decline in program enrollment," says Lynn Read, acting administrator of the Oregon Office of Medical Assistance Programs. "It's clear that there were significant hardships as a result of premiums."

An analysis by the Kaiser Commission on Medicaid and the Uninsured found that 72 percent of those who had been disenrolled from Medicaid had remained uninsured. Only 11 percent returned to OHP, and even fewer found employer-sponsored coverage.

The analysis also noted that physicians in the Portland area reported that patients were "self-selecting not to schedule follow-up visits, and, as a result, their health outcomes are getting progressively worse." One Medicaid participant said she raised money for her co-payments by buying small bags of potato chips with food stamps and then selling them for cash in office areas of her community at lunchtime.

Advocates in Oregon sued the state and the federal government over the mandatory premiums and co-payments, saying CMS did not have the authority to waive statutory restrictions on cost sharing. The state government prevailed on the premiums issue but not on co-payments. It has not enforced co-payments under OHP Standard since June 2004.

Some states have since held off on plans to seek waiver approval for stricter cost-sharing requirements, and several state health care officials have expressed their doubts about its effectiveness, particularly for the most financially vulnerable. "There may be some argument for selective co-payments, in areas such as inappropriate ER utilization," says Mark Moody, administrator of the Wisconsin Division of Health Care Financing. "But seeking 'flexibility' in this area is often code for 'flexibility to cut benefits.' "

—Gary Enos

Tools to Live By

Improved management is one way to stretch Medicaid dollars and improve quality of care.

"The old model for Medicaid programs was we were bill payers, but there has been a renewed call for better management," says Doug Porter, assistant secretary of the Department of Social and Health Services in Washington State. Today, he says, "You start reconsidering what it is you're buying, why and how you pay for it, and who you buy it for. You shift from paying claims to managing the demand on your program."

One of the most effective tools for better management of Medicaid has been managed care. In recent years, a growing number of states have moved many of their Medicaid beneficiaries into such programs. Many pay a per capita fee for the care of each patient (so-called capitated plans), transfering financial risk to the managed-care organization. Providers, at the same time, can be rewarded for providing better care—not just more care.

A report by The Lewin Group, a health care consulting firm, noted that capitated managed care saved Florida 8 to 9 percent compared with fee for service. Similarly, the

Bleeding Dollars

Stanching the flow of misuse and abuse confronts a hard reality.

Florida reimbursed $11.6 million to providers for services rendered after patients had died. A provider in California was found guilty of billing 32 hours of services on a single day. In New York State, physicians bilked the system by prescribing HIV/AIDS drugs for bodybuilding purposes, school districts were reimbursed for phantom speech services, and ambulance carriers paid beneficiaries to pretend they needed transport.

There is fraud, waste and abuse in the Medicaid program, much of it coming from providers. The issue gained national prominence last year after an exhaustive *New York Times* investigation exposed rampant overpayments that occurred in New York State.

The most egregious problems tend to be intentional abuses. The more common ones may be simple mistakes. States that have excelled in pursuing overpayments of both kinds have developed a number of tools that make the job easier. In 1999, California created a fraud prevention bureau and added more than 250 staff for the effort. California collects fraud referrals and coordinates with other agencies to audit, investigate and apply sanctions. Total savings after expenses through 2003 were $80 million.

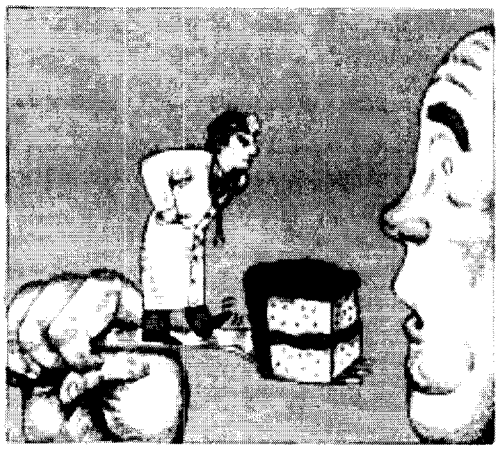
Tennessee set up a special inspector general's office. Illinois does on-site inspections of high-risk providers. It conducts criminal background checks before admitting some providers into the program and has a probation period for the first 180 days of enrollment. South Carolina has improved its recovery rate by upgrading its technology and analytical capabilities and by emphasizing

legislative analyst's office in California estimates in a 2004 report that its managed-care system saves the state "hundreds of millions of dollars annually." No surprise then that many states are now expanding their managed-care programs and including the disabled and elderly.

Success, however, requires maintenance and oversight. Consider Illinois. It has served only 10 percent of its Medicaid beneficiaries that way and not necessarily well. A 2004 U.S. District Court decision about health care access found that Illinois' managed-care companies offered children on Medicaid less in the way of preventive services than fee-for-service systems. A Lewin analysis found that money actually spent on medical services, as opposed to administration or profit, was as low as 49 percent in one managed-care organization, compared with well over 85 percent by managed-care groups in such states as Washington and Pennsylvania. The more successful programs used independent enrollment brokers (to avoid excessive marketing costs), client education, technology to monitor encounter data, skilled individuals to provide oversight and independent evaluation.

One advantage to managed care is that it lends itself more readily to tracking and charting providers through quality measures, and states are increasingly utilizing their capacity to do this. In Virginia, for example, a managed-care performance report records the quality of care and outcomes for patients.

Medicaid managers also have access to an accreditation process through the National Committee for Quality Assurance. The NCQA, in collaboration with *U.S.News & World Report*, has ranked a number of its accredited Medicaid managed-care plans in terms of how thoroughly they cover areas such as breast cancer screening, child immunization, flu shots for adults and eye exams for diabetics.



An alternative approach in managed care is primary care case management. This system pays providers to manage the care of an individual, while still permitting the same provider to charge for individual services. The point here is not the payment system so much as establishing case-management services and physician responsibility for a set of patients. Arkansas, for example, has been successful at establishing case-management programs through physician networks. The system still operates on a fee-for-service basis, but by giving doctors an administrative fee per member each month and offering them administrative extras—such as quick payment and electronic tools—patients end up with a medical home. When Arkansas started this program, "right off the bat our emergency room use started an instant decline," says Roy Jeffus, director of the Arkansas Division for Medical Services.

Damage Control

Many of the principles behind case management stem from disease management, a tool that appears to have great potential. The idea is to supervise the overall care of patients with chronic diseases to prevent health crises and avoid unnecessary hospitalizations. "This is the next generation in improving care by managing it better," says Brendan Krause, a health analyst at the National Governors Association.

With disease management, a Medicaid program can take utilization data and mine it to identify those who suffer from a particular condition and then communicate with them directly. Individuals who have asthma, for example, can be asked to participate in a program that educates them on the effectiveness of anti-inflammatory drugs. In North Carolina, the asthma program lowered hospital admission rates by 34 percent, and costs per beneficiary by 24 percent.

civil recoveries and the state's False Claims Act, which enables it to collect three times damages in civil cases.

One area of unintentional waste has been third-party coverage. Private insurance, the Veterans Health Administration or Medicare can sometimes be responsible for charges that have been paid by Medicaid. By pursuing such claims, Maine's Third Party Liability Unit recovered $17.7 million from third-party payers.

In many states, efforts to eliminate improper payments are not a priority, and resources are not the only issue. One particularly pernicious problem is the very real threat that when a state cracks down too aggressively, providers—many of whom are underpaid anyhow—will quit the Medicaid program. Ohio's Inspector General found that seven speech and hearing centers had overcharged the program $3.4 million. The state settled for $155,000 from two of the seven and prosecuted one.

Ohio's surveillance and utilization review chief, Jeff Corzine, said that vigorously pursuing the providers "essentially would have wiped out almost every speech and hearing center in the state, and we would have then lost a service for our population." Since the providers had exploited a loophole in the Medicaid billing cycle, the Medicaid office chose to educate the speech and therapy centers, letting most providers off with a warning.

Collin Wong-Martinusen, the director of California's Bureau of Medi-Cal Fraud and Elder Abuse, points out that unnecessary losses to Medicaid directly contribute to the real reason many Medicaid programs are unable to attract skilled health care providers: Reimbursement rates are woefully inadequate. The aggressive combating of Medicaid overpayments, he says, "will indubitably allow states to retain the level of resources necessary to build and sustain a vibrant provider network." **—Misha Segal**

At least half of the states have started at least one disease management program. Most have not yet seen significant savings but believe they will in the long term—an optimism borne out by the experience of commercial managed-care plans. In those plans in 12 states, the overall costs per diabetic patient fell by nearly 25 percent. Some of those savings came from a 30 percent decrease in admissions to the hospital.

But the upfront costs are a big barrier for many states. State legislators are focused on the current budget cycle. "Many of the things we're promoting take time to see results," says Melanie Bella, a vice president with the Center for Health Care Strategies and former Medicaid director in Indiana. "There's pressure to show savings within timeframes that aren't realistic."

One reason some states have hesitated to utilize disease management was a disappointing experience in Florida. But Florida's effort, which got underway in 2001, was unique. It relied on contracts with large drug companies to provide disease management services for patients with serious conditions. Under the contracts, state payments were based on actual cost savings. A May 2004 report by the state's Office of Program Policy Analysis and Government Accountability found that the cost savings were overstated and that the Medicaid agency hadn't adequately assessed the health outcomes of the patients to see whether there was improvement. The state legislature ended the experiment with private drug companies. "One of the lessons learned is maybe it's more appropriate to do disease management in conjunction with managed care—rather than one disease, one eligibility group at time," says state Medicaid director Tom Arnold.

—Rebecca Adams and Misha Segal

Trading Places

Moving the working poor out of Medicaid and into private health coverage is a slow go.

Few proposed solutions to the Medicaid conundrum seem more intuitively simple than shifting beneficiaries—notably those who hold down jobs—to employer-sponsored insurance. For the mere price of a premium, the responsibility for a whole family could be lifted from Medicaid's shoulders. Even employees of companies with skimpy benefits can be assured of reasonable benefits if Medicaid provides wrap-around coverage. But this is not as easy as it appears.

For starters, private-sector options are shrinking. The percentage of workers under age 65 covered under employer-based insurance dropped from 69 to 60 percent between 2000 and 2005.

Obviously, many workers who don't get employer-based insurance are low-wage earners, and the lower their income, the less likely they are to be covered. In addition, many private plans include cost-sharing provisions that are simply unaffordable. There is also an opposing tide emerging: Employers in service industries are, in effect, encouraging employees whose families are eligible for Medicaid to sign up for the public program.

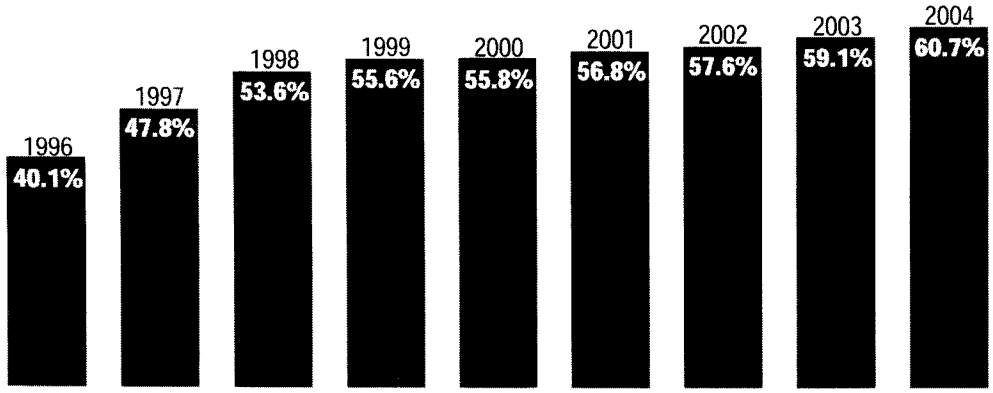
Still, the combination of a politically popular push for self-sufficiency among Americans and the potential savings available when private-sector insurance provides coverage makes states eager to cut through the thorny thicket of obstacles. Many of the experiments they are trying involve subsidizing the private sector with premium assistance.

Joan C. Alker of Georgetown University's Health Policy Institute has closely studied states' efforts in this area and has discovered that many states provide a set level of assistance for any kind of insurance coverage—even if it's inferior to that offered by Medicaid.

Illinois, for example, offers premium assistance of up to $75 per child per month in the KidCare Rebate portion of its KidCare State Children's Health Insurance Program (SCHIP). Private insurance for these children is required to cover physician and family hospital services, but the insurance can fall short of SCHIP coverage. States such as Illinois and Utah have argued that they guarantee the cost-effectiveness of their premium assistance

Medicaid Management

Percentage of total Medicaid population enrolled in managed care, 1996–2004



Source: Centers for Medicare & Medicaid Services

programs by capping subsidies and requiring enrollees to bear the rest of the costs.

Alker found that these states risk trading off controlled costs for limited use. She found, for instance, an enrollment in Utah of fewer than 80 people. "They're not moving enough people over, so they're not making up for their administrative costs," she says. Of greater concern, she adds, is that some states are not even analyzing the financial impact of their programs.

Alker found that some states, such as Rhode Island and New Jersey, offer more generous subsidies (including wrap-around insurance that guarantees coverage at least as good as that in Medicaid). Those states have been able to drive enrollment up and demonstrate cost savings to boot.

Oregon provides premium assistance for more than 10,000 citizens. It pays up to 95 percent of employee costs for workers, based on income. The coverage must meet a set of requirements that is actuarially equivalent to the federal Medicaid benefit. Lynn Read, acting administrator of the Oregon Office of Medical Assistance Programs, says that employer incentives could yield even better results.

Right Sizing

Although premium-assistance programs are still in the early stages in many states, Rhode Island seems to have jumped ahead of the pack. Anyone in the state's RIte Care Medicaid program who can be covered in a more cost-effective way by employer insurance must enroll in that plan. To date, 6,000 Medicaid and SCHIP beneficiaries have done so. That's about 500 more people than are enrolled in Illinois' program, although Illinois has 11 times the number of SCHIP beneficiaries.

The effort—dubbed RIte Share—grew out of a 1998 program in conjunction with welfare reform. State officials wanted to make sure that adults moving from cash assistance into jobs had health coverage.

But the state underestimated the cost of success. Not only did the welfare-to-work population migrate to RIte Care, an aggressive outreach effort resulted in many uninsured families enrolling for the first time. This, coupled with a major private insurer leaving the state, caused unexpected budget problems, with the state having to find $50 million in the first year to make up for its inaccurate enrollment projection.

"We had to do something to stabilize the growth, but we didn't want to cut back on benefits," says Tricia Leddy, an administrator of RIte Care Medicaid. So in 2000, the state established the RIte Share premium-assistance program. The state subsidizes employees' costs based on their income and offers wrap-around coverage to fill any gaps between Medicaid/SCHIP coverage and the employer-based insurance. Individuals carry two insurance cards: their primary employer insurance card and their secondary coverage Medicaid card, which can cover co-payments at the doctor's office or pharmacy.

State officials have carefully analyzed costs associated with RIte Share, comparing them with Medicaid managed care. "We estimate that for every 1,000 enrollees in RIte Share, we achieve $1 million in savings," Leddy says.

States that want to emulate Rhode Island should beware of one landmine: The program will inevitably increase administrative costs. The churning effect from people moving in and out of the program is quadrupled in premium assistance, and states must keep track of varying insurance-plan limits, employees' changing job status and instances when employers are acquired by another entity.

A Unique Approach

In 2003, Arizona developed a state-sponsored insurance program open to businesses with 50 or fewer employees, government agencies and the self-employed. It offers a cafeteria plan of benefit structures and pricing, and the coverage can be funded either by employers or employees.

About 16,000 people are covered under this plan, and the state breaks even on it. So what's the benefit? "About 12 percent of our beneficiaries would qualify for our Medicaid program if they applied," says Anthony Rodgers, director of the state's health care cost-containment system. "We see this as cost avoidance. At the current level, we're saving around $5 million in the state portion of general Medicaid funds each year."

Despite its potential promise, Rodgers does not see state-sponsored plans gaining traction elsewhere. Many are fearful of going into competition against powerful traditional insurance companies. **—Gary Enos**

The Radical Reformers

Moving forward with an untested approach.

Many of the ideas for controlling Medicaid costs are aimed at saving significant sums of money without changing the fundamental nature of the program. One concept is different. It upends the bedrock principle that low-income patients have an open-ended entitlement to a broad range of hospital, outpatient and other medical services when they need them. Both Florida and South Carolina are planning to cap the coverage provided their Medicaid beneficiaries.

Florida is in the lead, with a waiver approved in October by the federal Centers for Medicare & Medicaid Services. The plan sets aside a specific amount of money for Medicaid beneficiaries and requires that they use their allotment—in effect, a voucher—to buy health-care coverage from private insurers. People who are sicker will be entitled to higher-value vouchers to allow them to buy more care. While some children and pregnant women will still receive the whole range of benefits mandated under existing Medicaid law, most adults and many of the disabled will not.

"What we're trying to do," says Tom Arnold, Florida's deputy secretary for Medicaid, "is bring some certainty to the process."

The Florida program, which will rely heavily on managed care, is expected to be implemented as a pilot project this year in Broward and Duval counties, affecting 200,000 of the state's 2.2 million Medicaid beneficiaries.

Officials in Florida and in South Carolina, which has a similar proposal in the works, argue that one advantage of the program is its simplicity: It cuts down on red tape and gives private plans more leeway in designing benefits.

They also see potential for cost savings. Officials believe that the marketplace will force insurers to compete with each other, offering ever-better benefits at lower prices. In addition, the private sector could help slow Medicaid's growth as private plans—specifically managed-care plans—find more ways to save money.

The potential payoff of a better bottom line, says Robert Kerr, director of South Carolina's health and human services department, is worth the gamble for both insurers and the states. "If managed care saves money, the plans keep most of that. So what do we get out of it? We get no growth."

Causes for Concern

Critics have a laundry list of worries about the plans. For Joan Alker, senior researcher at the Georgetown University Center for Children and Families, the proposals are "based on largely untested concepts which will result in the state's most vulnerable residents being asked to pay more and receive less for their health care." Capping the amount of money that the state spends per person does not mean that the health needs of vulnerable families go away. Rather, "their needs will go unmet, which will result in a sicker population, growing levels of uncompensated care, and cost-shifts to private payers."

Officials in Florida and South Carolina say beneficiaries will not be harmed by limits on their allotments because those allotments will be based on historical claims data for people with their conditions. State officials also say Medicaid will step back in with more funding for catastrophic care if a beneficiary's health requires care beyond the allotment in any given year.

The reliance on insurance companies to pick up slack worries some observers who point out that insurers have a duty to look out for their own bottom line as well as an individual patient's well-being.

There are other key concerns:

- Handing each patient a predetermined subsidy based on health status is risky, since quality of health is not very easy to predict.
- Managed care plans and other networks may not want to participate.
- Medicaid recipients—particularly those with limited education—may be overwhelmed when it comes to picking a plan that best covers their needs.

Only time will tell how successful Florida's pilot efforts will be. One thing is sure: The rest of the states will be watching closely.

—Rebecca Adams

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Michigan Report

January 5, 2006

WIDOWS BEWARE: PANEL DISCUSSES ELDER ABUSE

Governor Jennifer Granholm's Task Force on Elder Abuse pondered ways to hold abusers accountable, Thursday, and prosecutors' suggested specialized training and stricter enforcement.

The 17-member task force was created last May to identify and prevent elder abuse issues ranging from physical neglect to financial exploitation. The panel, chosen by the governor, includes stakeholders from law enforcement agencies, attorneys, state departments and the public. They are responsible for creating a final report of recommendations by May 2006.

Tom Robertson, executive director for Michigan Prosecuting Attorneys' Coordinating Council said the range of crimes makes it necessary to provide a range of training.

"We need increased training at all levels, from home care givers to investigators," he said.

Prosecuting attorneys said offenders often serve little or no jail time because of a sentencing model that relies on factors such as the magnitude of the crime and habitual offenses.

Jeffrey Sauter from the Prosecuting Attorney's Association said guidelines should be redefined to consider the vulnerability of older adults, as they are often targeted for financial crimes because they are lonely, trusting and often too embarrassed to report crimes.

Examples of financial exploitation came up throughout the day-long meeting. Detective David Kelley from the Southeast Criminal Special Investigative Division told a tale of the "widow web finder."

Mr. Kelley described how an older gentleman swindled dozens of Michigan widows using match.com, a popular web dating site. The perpetrator would target the women, based on age and income, and trick them into phony business ventures, or just steal their money. The man continued this practice even after he was released on bond and tethered.

Mr. Kelley said, despite the multiple offenses, the man had no criminal history and despite the more than $100,000 he embezzled from his unsuspecting girlfriends, he received just a five-year prison sentence.

David McClorey, from the Wayne County Prosecutor's Elder Abuse Office, echoed this sentiment as he advised the panel to seriously consider the dangers in financial fraud because, "dumb people commit armed robbery, but smart people commit embezzlement and fraud."

A representative of the State Police said they can't track the number of elder abuse victims because of police reporting procedures. Sgt. Michele Hernandez, a task force member representing the State Police, said the department is currently working with Michigan State University to include age and crime demographics for reporting practices. She said that will allow police to better understand the scope of the crimes committed against senior citizens and vulnerable adults.

Sharon Gire, director of the Office of Services to the Aging, said it's estimated that between 5 to 10 percent of the elderly are somehow abused. In Michigan, that translates to about 80,000 people a year, according to Ms. Gire.

"What we do know is there are thousands of unreported cases," she said adding that public awareness is key to confronting elder abuse issues. "The reality is that as older people begin to look for assistance and guardianship, they need to know how to protect themselves."

Battle Creek Enquirer

EDITORIAL

Scams prey on our hopes of getting rich quickly

Who among us hasn't fantasized at one time or another about becoming independently wealthy, able to do what we want, when we want?

Such fantasies have provided profitable fodder for con artists for years. But today's high-tech world has made it increasingly difficult to distinguish between scams and legitimate offers as con games proliferate around the world.

One of the latest scams in the Battle Creek area sends checks to recipients, with accompanying letters saying they have won hundreds of thousands of dollars, often in a foreign lottery. The recipient is told to cash the check, then send a money order (usually for a little bit less than the check) to an address as a "bond" for the big jackpot.

But as one area man recently discovered, when the check proves to be fake, the bank can come after you for the money.

Last month, Michigan Attorney General Mike Cox said his office also has had a spike in complaints about people falling victim to telephone scams that seek to obtain personal bank account information. Other scams involving the new Medicare prescription-drug benefit have popped up across the country in recent months, taking advantage of many older Americans' confusion about the multiple choices they face in signing up for the drug benefit.

Con artists frequently target older or isolated people who may be lonely and are especially vulnerable to a friendly - and persuasive - voice. It is important to realize that just because someone *sounds* honest, doesn't mean they are.

Security experts stress the importance of *never* providing personal information (Social Security numbers, credit card accounts, bank accounts - even birth dates or maiden names) to someone who calls you. Such information can providing a opening for a con artist to rob you.

The simplest way of avoiding being a victim of a scam is to refuse to do business over the telephone or computer with anyone who contacts you. If such a contact intrigues you and you want to pursue it, the attorney general's office recommends confirming the identity of the caller, then hanging up and going to a reliable source (phone book, a bill, statement, etc.) to get the telephone number of the caller. Then call the identified source to confirm that the information from the prior call is legitimate.

Experts say that one of the biggest red flags when it comes to identifying scams is if a caller tells you that you have won cash, a trip or prizes, but says that you must pay for "postage and handling" or "insurance" or "taxes." Legitimate offers seldom require such money up front.

Also resist pressure to "act now" before the offer expires. Never take any action until you have verified the truthfulness of the offer.
If you have a question about a company or want to lodge a complaint, you can call the Better Business Bureau of Western Michigan at 800-684-3222.
If you think you may have been the victim of a scam, contact your local law enforcement agency.

Originally published January 6, 2006

Anti-scam advice offered

Friday, January 06, 2006

The Grand Rapids Press

MECOSTA COUNTY --
Sheriff's officials will hold an hour long seminar Jan. 19 to help prevent seniors citizens from being scammed out of their money by telephone and mail solicitations. Capt. Gary Lenon will advise caregivers and seniors how to spot indicators of fake fundraisers, lotteries and charitable groups during the 10 a.m. session at the county's senior center, 12954 80th Ave. Lenon said people should never reveal personal identification or give bank numbers to others.

Man, 27, charged in girl's beating

Friday, January 06, 2006

By Scott Hagen
shagen@citpat.com -- 768-4929

A police photo of a 4-year-old girl shows her with a big smile, despite the two black eyes and purple bruises nearly covering her face.

The smile is still there even though 27-year-old William Trainer, who was living with the girl and her mother, is charged with beating her Tuesday night while watching her.

Trainer was arraigned Thursday in District Court on a charge of assault with intent to do great bodily harm and a charge of second-degree child abuse.

Prosecutors allege Trainer, who is 6 feet, 4 inches and weighs 280 pounds, struck the child on both sides of the face, threw her against a wall and repeatedly pounded her on the buttocks after she broke a Christmas present.

The girl has bruises on both temples, two black eyes, black, blue and purple marks up and down her cheeks, heavy bruising on her buttocks and scratches on an elbow.

Trainer himself called the Department of Human Services, a government branch that oversees child welfare.

"I called them right after I did it," Trainer said during his arraignment.

Trainer, who had been living with the girl and her mother for about eight months, told police the beating occurred during a fit of rage and that he probably needed anger management.

Chief Assistant Prosecutor Mark Blumer said Trainer was a "clear and present danger" to the community and asked the court to consider the "extreme brutality the victim suffered," as well as Trainer's loose ties to the community in determining the bond.

"It's a very serious matter, and I have verified the injuries are severe," Magistrate Fred Bishop said before setting a $100,000 bond for Trainer, who will appear Jan. 18 in District Judge Darryl Mazur's court for a preliminary examination.

If convicted, Trainer could face up to 10 years in prison for the assault charge and up to four years in prison for the child abuse charge.

"This was a brutal attack on this child. And her crime, to justify this assault, is that she broke one of her toys," Blumer said.

"There's simply no excuse, no justification and no apology that's going to make this better."

Boy, 3, found sitting on cocaine in car

Friday, January 06, 2006

By Scott Hagen
shagen@citpat.com -- 768-4929

Two men were arrested this morning for drug possession and child endangerment after an officer found a 3-year-old boy sitting on 63 packets of cocaine in the backseat of their car.
Police stopped the black Cadillac after employees at the Sauk Trail Post on Prospect Street called 911 to report a fight and a single shot fired at the club shortly after closing at 2 a.m.
No one was injured by the shot, but witnesses saw a black Cadillac driving away from the club.
A Jackson police officer stopped a car matching that description three minutes later at the corner of Euclid and Francis streets.
A search found the 3-year-old sitting on the packets of cocaine in the backseat, said Jackson Police Deputy Chief Matt Heins. The packets were stacked in a car seat and the boy was sitting atop the packets.
Heins could not place a street-value on the drugs found, but said it was a "substantial amount."
Heins said police are still investigating the two men's involvement in the shooting incident.
The 30-year-old driver from Detroit and his 29-year-old passenger from Albion are expected to be arraigned today. Their names are being withheld until then.
The boy's father, from Albion, later told police he asked one of the men to take the child to family members in the Albion area, and that he was unaware of drugs in the car.

January 6, 2006

Kingsley man faces sex abuse charge

FROM STAFF REPORTS

TRAVERSE CITY - A Kingsley man is being sought on an arrest warrant for allegedly fondling a underage girl at his home.

A charge of second-degree criminal sexual conduct was filed against Scott Gear, 41, in 86th District Court this week after an alleged incident in November involving a 14-year-old girl.

The teen told Grand Traverse County sheriff's deputies that Gear allegedly inappropriately touched her at his home on Sleepy Hollow Trail in Kingsley.

A conviction on the charge is punishable by up to 15 years in prison.

Amber Alert Called Off For Detroit Teen

Mentally Challenged Boy May Have Missed School Bus

POSTED: 6:09 pm EST January 5, 2006

An Amber Alert has been canceled for a 15-year-old mentally challenged boy who was reported missing around 10 a.m. Thursday.
A woman and her daughter found Stephen Dewayne Spicer walking the streets of Highland Park Thursday afternoon, Local 4 reported.
They took him to the Michigan State Police post in Detroit at West Grand Boulevard and Woodward, according to the station.
Spicer allegedly became agitated when he missed a bus to Renaissance High School and then wandered away from his home on Tuxedo Street, in the area of Six Mile Road and Outer Drive, police said.

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Cadillac News

January 6, 2006

New legislation to help keep students safe

CADILLAC - A new piece of legislation that became effective on Jan. 1 will help to make students safer at school.

The legislation establishes new crimes for certain actions by individuals who are required to register as sex offenders by the Sex Offenders Registration Act and creates "Student Safety Zones," according to a joint release by the Cadillac Police Department, Cadillac Michigan State Police, Wexford County Sheriff's Office and the Wexford County Prosecuting Attorney.

The zones are the area that lie 1,000 feet or less from school property and the legislation now makes it a crime for registered sex offenders to work, live or loiter in a student safety zone. Loiter means to remain for a period of time and under circumstance that a reasonable person would determine is for the primary purpose of observing or contacting minors, the release said.

An individual convicted after Jan. 1 of an offense requiring sex offender registration must move within 90 days if he/she lives in a student safety zone.

Sebewaing man faces 3 felony counts linked to Wednesday a.m. incident

STACY LANGLEY
The Huron Daily Tribune

01/06/2006

BAD AXE — The 21-year-old Sebewaing man who was arrested in the front yard of a Sebewaing home after a brief stand-off with police now faces three felony charges and two misdemeanor charges in connection with the Wednesday morning incident.

Donald J. Kothe was arraigned Wednesday in Huron County District Court on charges that include assault with a dangerous weapon. If convicted, he faces a possible sentence of up to four years in prison and/or a $2,000 fine. The charge was filed after the Wednesday incident in which police claim Kothe "challenged" Sebewaing Police Officer Chris Eisengruber with a shotgun both inside and outside the home.

Eisengruber was called to the 212 Sharpsteen St. home after a female who was in the home went next door reporting Kothe's threatening behavior, and 9-1-1 was called just before 1 a.m.

According to the Huron County Prosecutor's Office, when Eisengruber arrived on the scene a reportedly intoxicated Kothe, allegedly in possession of 20-gauge shotgun, was inside the home "trashing the house."

Kothe faces two additional felony charges which include assaulting, resisting, obstructing or endangering Officer Eisengruber. The third charge is a felony firearms charge which alleges Kothe possessed the shotgun at the time he committed or attempted to commit felony assault. Both charges carry a possible sentence of up to two years in prison.

In addition of the three felony charges, Kothe was arraigned on two misdemeanor charges that include domestic violence, which carries a possible sentence of up to 93 days in jail, and a charge of malicious destruction of personal property valued at $200 or more but less than $1,000. The malicious destruction of personal property charge carries a possible sentence of a year in jail and fines.

According to police reports, Kothe, who turned 21 on Tuesday, was intoxicated at the time of the incident and apparently suicidal.

He was taken into custody after coming out of the house into the front yard armed with the shotgun, allegedly "challenging" Eisengruber with the gun.

Eisengruber, with the assistance of Huron County Sheriff's Deputy Josh Powell, was able to use pepper spray on Kothe. He was taken into custody by police and treated for minor injuries he sustained and later lodged in the Huron County Jail.

Kothe's preliminary examination was set for Jan. 12 in district court. His bond was set at $7,500/10 percent.

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Boyfriend Heads To Prison For Troy Murder

20-Year-Old Woman Killed In June

POSTED: 11:42 am EST January 5, 2006

PONTIAC, Mich. -- A Bloomfield Hills man convicted of beating his girlfriend with a baseball bat, then stabbing her and dumping her body into a garbage can, was sentenced Wednesday to life in prison without possibility of parole.

Amir Aziz Shahideh was found guilty of first-degree murder Dec. 8 in the slaying of Leila Armin, 20, who had broken up with him in the days before she was killed on June 16.

Shahideh, 24, received the mandatory sentence from Oakland County Circuit Court Judge Steven Andrews at a hearing Wednesday afternoon.

Jurors in his trial deliberated about 4 ½ hours before finding that he planned the murder of Armin at her home in Troy.

Shahideh's lawyer had argued that the killing was an impulse rather than premeditated.

January 6, 2006

TC man accused in sexual assault case

FROM STAFF REPORTS

TRAVERSE CITY - A local man is in trouble for allegedly threatening to kill a woman in an attempt to force her to have sex.
Christopher Wayne Rathjen, 48, of Traverse City, is charged with felony criminal sexual conduct assault after he allegedly threatened the victim on Saturday.
The victim told Grand Traverse County sheriff's deputies that Rathjen allegedly assaulted her and threatened to kill her if she didn't have sex with him.
Rathjen also is charged with misdemeanor domestic violence and cutting a telephone line after he allegedly destroyed a phone.
Rathjen is held on a $2,500 bond.

Detroit Free Press

Editorials

Stay Homeless

Pontiac forsakes a grant, and a possible solution

January 6, 2006

The National Coalition for the Homeless ranked Pontiac the nation's fourth meanest city in 2002, and now the city appears to be fighting for the top spot.

City Council members last month rejected a $1-million state grant to provide housing for the homeless -- a move that almost certainly will worsen the city's homeless and economic problems. Pontiac's council and mayor think the city has too many halfway houses and shelters, and they're worried about the impact of homelessness on the city's downtown development.

A certain amount of defensiveness by Pontiac officials and residents, who sometimes see their city as Oakland County's dumping ground for the homeless problem, is understandable. But there is little evidence that many homeless people come from outside the community. The shelters are in Pontiac -- as opposed to, say, neighboring Bloomfield Hills -- because that's where most of the area's homeless, and near homeless, come from. Pontiac can ignore the problem and watch it get worse, or try to deal with it in a compassionate and smart way.

The City Council and mayor ought to reverse their position,
take the state money and use it to benefit Pontiac and the homeless. City leaders could locate the housing outside downtown and ease the homeless problem in the business district.

The state grant, if used as intended, would permanently take people off the street by funding long-term housing and programs that prepare people for jobs and help them stop abusing drugs and alcohol. Similar programs elsewhere in the country have reduced costs to cities by lowering the need for emergency services and jail cells.

By thumbing its nose at this
$1-million grant, Pontiac leaders will only make the city's homeless problem and business climate worse.

Friday, January 06, 2006

Cop cleared in homeless man's death
Wayne County jury acquits trooper of second-degree murder charge in April killing.

Norman Sinclair / The Detroit News

DETROIT -- On Nov. 30, Michigan State Trooper Jay Morningstar, facing murder charges that could have put him in prison for life, rolled the judicial dice with a Wayne County jury by rejecting a plea deal that would have guaranteed his freedom.

On Thursday morning, he won that gamble when a 12-member jury acquitted him of second-degree murder and manslaughter charges in the April 14, 2005, shooting death of Eric "Magoo" Williams, a 40-year-old homeless Detroiter who roamed downtown streets panhandling pedestrians near Greektown.

Jurors deliberated for four hours before clearing the 35-year-old Morningstar, a six-year trooper and a decorated veteran.

"We are absolutely gratified that this jury saw through these charges and did the right thing," said Sgt. Mike Herendeen, president of the Michigan State Police Troopers Association. "We knew he did the right thing, and we were confident it would be displayed at trial. Still, it's a difficult concept, you've got a tragic situation, and you really need to count on the jury to come through for justice."

Wayne County Prosecutor Kym Worthy said she was disappointed.

"We always thought the jury needed to hear and decide the facts. This case is a stark reminder that no one is above the law," she said in a statement.

Morningstar encountered Williams after midnight, shortly after the trooper had made a traffic stop and was driving toward the freeway. Morningstar observed a disturbance in front of the Detroiter bar and stopped to investigate.

Prosecutors said Morningstar shot Williams in the chest as Williams approached the trooper with his hands obscured and disobeying commands to stop. Moments earlier, Williams had been bounced from the bar, pulled down his pants, tossed a chair and broke two windows.

A toxicology report showed Williams had a blood-alcohol level of 0.24, three times the legal limit for a drunken driving conviction.

Herendeen said fellow officers were so outraged by the charges against Morningstar that they collected more than $20,000 for his defense.

The department put up $50,000 and has retained former assistant U.S. attorney Richard Convertino for him for any civil action that may arise from the case.

Herendeen said the case could put a chill on officers taking similar action in the future.

In November, prosecutors offered Morningstar a deal: plead guilty to one count of manslaughter and serve three years probation. He turned it down.

Neither Morningstar nor members of Williams' family could be reached for comment.

You can reach Norman Sinclair at (313) 222-2034 or nsinclair@detnews.com.

Energy tweaks earn credits
Tax breaks offered for efficient items

January 6, 2006

BY ALEJANDRO BODIPO-MEMBA
FREE PRESS BUSINESS WRITER

Installing energy-efficient windows or buying a high-efficiency furnace could net homeowners up to $500 in federal tax credits.

The Michigan Public Service Commission announced Thursday the start of the federal home energy efficiency improvement tax breaks for making those home upgrades over the next two years throughout the state.

A result of the White House energy package President George W. Bush pushed last year, the Energy Policy Act of 2005 allows homeowners to qualify for tax breaks totaling as much as $500 by installing qualified products such as energy-efficient windows, insulation, doors and heating equipment.

The law also provides a credit equal to 30% of qualifying expenditures for purchase of qualified photovoltaic property, such as solar panels, and for solar water heaters, except for swimming pools and hot tubs.

Improvements must be made in or on the qualified taxpayer's principal residence in the United States between Jan. 1, 2006, and Dec. 31, 2007.

"With rising home energy costs, it is more important than ever that homes be energy-efficient," MPSC Chairman Peter Lark said in a statement. "The new tax credits for making energy-efficient improvements can result in big savings."

Examples include earning $50 for buying an advanced main air circulating fan, $150 for installing a highly efficient furnace or boiler and $200 for putting in energy-efficient windows.

For more information on the details, homeowners can log on to www.energy.gov/taxbreaks.htm.

*Contact **ALEJANDRO BODIPO-MEMBA** at 313-222-5008 or bodipo@freepress.com.*

Where to get help

- People who need help paying their heating and electric bills have several options:
- Check with your utility provider about Budgetwise or Winter Protection billing plans. Customers of Detroit Edison and MichCon can call 800-477-4747. Customers of Consumers Energy can call 800-477-5050.
- Low-income residents and people facing financial crises can call the Heat and Warmth Fund (THAW) for emergency payment assistance. In southeastern Michigan, residents can dial 211. In Muskegon County, the Red Cross emergency line is 231-726-3555.
- All other areas in Michigan can call THAW at 800-866-8429.
- Information about the Home Heating Tax Credit can be found at the Michigan Treasury Department by calling 800-367-6263.

Police chief asks: Why do kids become killers?

Friday, January 06, 2006

By Ken Kolker
The Grand Rapids Press

GRAND RAPIDS -- Grand Rapids Police Chief Harry Dolan stirred up local minority leaders last year when he questioned what he believed was their lack of outrage over violence.
He pointed out the faces of the city's dozen murder victims in 2004: all minorities, most black.
Little has changed in a year, at least when it comes to the faces of murder -- 16 of the city's 19 victims were minorities in 2005, according to police.
Now, Dolan says he is taking the next step in responding to violent crime.
His department will study backgrounds of those who kill, rape, rob and assault this year, he said.
His goal: To keep children from growing up into violent criminals.
"The children we neglect today will be the adults who prey upon us tomorrow," Dolan said.
"We're talking about breaking cycles."
Some black leaders questioned the need for the study, saying they know what police will find -- that most people arrested for violence are poor, uneducated and black.
They would prefer the city focus on solutions, such as better schools.
Grand Rapids police will learn as much as they can about suspects of serious violent crime -- education level, whether they live in poverty, race, criminal record, Dolan said.
They will be able to find much of the information in court records, such as pre-bond reports.
Dolan said he also hopes to delve more deeply into their background, if possible -- whether they were raised by a single parent and were victimized themselves.
At year's end, Dolan hopes to turn over the information to a criminal justice professor, perhaps at Grand Valley State University, who will look for common denominators.
"It keeps getting back to, 'Why did this occur? Why did somebody stand on the corner with a .357 and an ounce of crack cocaine?'
"We want to look at this holistically. Here are the common denominators that we as a community have got to be looking at."
Homicides in Grand Rapids jumped to 19 last year from 12 the year before.
Still, the city of nearly 198,000 people is safer than Flint, a city of 125,000, which had 30 homicides, and Saginaw, a city of 62,000 people, where 21 homicides were reported last year.
Some local black leaders were surprised the police department had not already conducted a study of violent offenders and questioned its value.
Donald Williams, dean emeritus of the Office of Minority Affairs at Grand Valley State University, likens the problems of minorities and crime to a snowball rolling down the mountain.
"People say, 'I wonder what's in the snowball?'" he said. "We know damn well what's in the snowball ... Minorities and poor people have been studied to death."
Kent County Commissioner Paul Mayhue, a black leader who has criticized the department's treatment of minorities, wondered how a study would help police.
"What is it going to gain us in terms of catching criminals?" he said.

If police find the focus should be on education, where will the money come from to improve an urban district that is closing schools? Mayhue asked. "You've got to bring some resources to the table."

However, Grand Rapids Urban League President Walter M. Brame welcomes a study, as long as it doesn't jump to wrong conclusions.

Just because most violent criminals are black does not make blacks violent, he said. The real factors are education, joblessness and hopelessness, he said.

"One of the dangers of doing the study wrong is it adds to stereotypes," Brame said.

Violent examples

Dolan said he would expect his study to look at such violent suspects as Ricardo Fabela Jr., who is wanted for the Feb. 13 shooting deaths of two men at a home on Buchanan Avenue SW.

Fabela, described by police as a black 19-year-old from the Dominican Republic, made it through ninth grade at Union High School, was unemployed, had no income and no assets. He lived with his family, but his father was in prison, court records show.

His juvenile history included arrests for kidnapping, felonious assault and resisting and obstructing police.

Of the 10 suspected killers identified by Grand Rapids police last year, background records were available for five.

Of those, three dropped out of school. Nine of the 10 murder suspects are minorities -- six blacks and three Hispanics, court records show. One suspect is white.

A challenge and responses

Last year, Dolan's challenge to minorities -- that they weren't doing enough to respond to violence in their community -- made his department a target.

Some black leaders criticized police, saying they were part of the problem. Police needed to communicate better and be held more accountable, some said.

The city's Community Relations Commission opened its microphones to residents who complained of police harassment and abuse -- charges denied by some city officials.

It was followed by challenges to the city's hindering and opposing ordinance, which some said was used by police to harass blacks who dared question them. The city re-wrote the ordinance, giving police the option of writing tickets rather than taking violators to jail.

Black religious leaders organized a "Say No to Violence" rally.

Dolan maintained his officers were trying to make neighborhoods safer, and disputed they were harassing blacks. Police, he said, were being demonized.

He said he wants to get away from "finger-pointing."

Mayhue, the county commissioner, said Dolan's challenge turned out positive. "It got people talking," he said. "It's a good thing to have people talking."

Boy, 13, to be tried in robbery

Trace Christenson
The Battle Creek Enquirer

A 13-year-old Battle Creek boy, Kevin Demott, has been ordered to stand trial on charges stemming from the Nov. 17 armed robbery of Little Caesars Pizza at 629 Capital Ave. S.W.

Calhoun County Juvenile Court Judge Gary Reed ruled Thursday there was enough evidence to send the case to trial Feb. 1 on one charge of armed robbery and three charges of assault with intent to rob while armed.

Demott is alleged to have entered the restaurant and demanded money from an employee and three customers. The robber fled the store without taking any money, and Demott was arrested a few blocks away by Battle Creek police. No gun was recovered.

Reed scheduled the jury trial before Judge Allen Garbrecht, a circuit court judge sitting in the family division. If Demott is found guilty, Garbrecht would hold a hearing to determine if he is sentenced as a juvenile or as an adult, or a combination. Demott faces up to life in prison on the charges.

Two of the three teenagers who were waiting for their pizza testified they saw Demott's face as he walked into the store and before he pulled down a ski mask.

"When he opened the door I looked up and then he pulled the mask down," said Shane McMillon, 16, of Battle Creek.

McMillon, Trevor Bannester, 16, and Travis Baker, 14, testified they were ordered to the floor by the gunman, who pointed a pistol at them.

"He said, 'Get on the floor and give me all your money,'" McMillon said. "And it looked like a pistol. He was waving it around and pointing it at us."

Baker testified Demott was wearing the ski mask on the top of his head as he began to enter the store but then pulled it over his face.

"He pulled the mask down and pointed the gun at us and told us to get on the ground," Baker said.

He testified Demott was "the same person I seen walk in."

During testimony that began in December, Bannester and a former store employee, Robby Patton, said they didn't see the gunman's face. Patton said he dropped behind a counter when the robber entered and he and other store workers hid until the gunman left.

Baker said he threw a few dollars in change on the floor but the robber left the money behind.

During questioning by Assistant Prosecutor Mike Lind and Defense Attorney J. Thomas Schaeffer, the witnesses gave conflicting descriptions about the color of the robber's hair, his height and weight and their estimate of his age.

Then Schaeffer argued that when police took the three young men to see Demott, who was in a police car not far from where officers arrested him,

the identification was tainted.
Schaeffer said Bannester, McMillon and Baker talked among themselves about their observations and that Demott was handcuffed and standing with police officers with a light on his face when shown to the victims. But Lind argued the issues of the credibility of the witnesses were for a jury to decide.

Trace Christenson covers crime and courts. He can be reached at 966-0685 or tchrist@battlecr.gannett.com.

Originally published January 6, 2006

Church to open child development center Heart of the Shepherd in Howell Township continues to build on impressive start

Friday, January 06, 2006

Ann Arbor News Staff Reporter

The Rev. Galen Grulke has his heart in it.
The teacher-turned-pastor helped a group of more than 100 families start and move into their new church, Heart of the Shepherd Lutheran Church last fall.
This month the church on Burkhart Road in Howell Township plans to open its new Child Development Center in the building's north wing.
The church and school are affiliated with the Lutheran Church-Missouri Synod. The intent of both is to draw new members and better serve the surrounding community, said Grulke, a Howell resident.
"We're not interested in being aquarium keepers; God wants us to be a fisher of men," he said, adding that he wants the church to be a good fit for those who come to worship. "We want to make sure God is pulling you here, not that you're being pushed away from another church."
It's also designed as a gathering place for community groups, such as a local Alcoholics Anonymous chapter that meets there weekly, he said.
The fledgling church, a daughter congregation of Shepherd of the Lakes Lutheran Church in Brighton Township, began services three years ago at the Livingston Educational Service Agency offices in Howell. A new multipurpose facility on 22 acres on Burkhart Road just south of I-96 designed and constructed by Bouma Construction of Grand Rapids was dedicated in November.
The church also is developing about 10 acres of walking trails through woods on the property, Grulke said.
Although it has a traditional worship service, contemporary multimedia services are offered on Sunday and Wednesday evenings. "We wanted to offer something a little different," he said. "It sets us apart from the majority of Lutheran churches in this community."
The new church building is designed to be multifunctional and accommodates up to 300 worshipers - or a game of community basketball during other hours.
The Christian-based preschool program is run by Howell resident and Child Development Director Cournti Holst, who is also Grulke's daughter.
The program is designed to serve more than 68 preschoolers from six weeks to 2 years old, as well as 60 elementary school children in before- and after-school activity groups in the church's multipurpose room. Because families can choose full- or part-time attendance, the number of children served could be more, she said.
"Not many programs offer that flexibility," Holst said. "Quality care in Livingston County is a great need."

Grulke said that although Heart of the Shepherd has grown since its inception, some were motivated by seeing the new building. "Some people say, 'Are you for real?' and want to know if you're going to survive," he said.

Members take different things away from their church experiences.

The Dickinson family of Marion Township found it more convenient than their church in Walled Lake.

"It seemed to be what we were looking for, and it was Bible-based," said Todd Dickinson, who attends with his wife, Susan, and sons Tyler, Mark and Matthew. "It's been rewarding."

Todd and Susan Dickinson also lead one of the community's small study groups, focusing theirs specifically on raising teenagers.

Howell resident Julie Smith serves as one of the church's two keyboardists and her craftsman husband, David, has helped design and install trim in the new church.

They attend Heart of the Shepherd with daughters Michele and Katie and had previously gone to Shepherd of the Lakes for nine years. They tried the new church which was three miles from home.

Julie Smith said being part of the new church planting was a great experience.

"From planning the church and watching it grow and just seeing what happens when it's started from scratch. Am I happy here? That's an understatement," she said.

"Everyone is made to feel welcome here and that's the thing that means a lot to me."

Casey Hans can be reached at chans@livingstoncommunitynews
.com or at (810) 844-2005.

New center

Friday, January 06, 2006

What: Heart of the Shepherd Lutheran Church is opening a new child development center this month.
Where: 228 N. Burkhart Road, Howell Township (south of I-96).
Hours: 6:30 a.m.-6 p.m.
Programs: Preschool programs are available full- or part-time. Parents can custom-design school for their children with everything from a full day to one or more 3 1/2-hour sessions per week. Before- and after-school programs also are available for students through fifth-grade.
Capacity: Center can accommodate 68 children aged 6 weeks to 5 years full time; more if children attend part-time. There are 60 elementary-age spots for children in the before- and after-school program.
Details: Courtni Holst, child development director, (517) 552-7218 or visit www.hotsheperd.org. A full schedule of rates plus a parent handbook are available online.

City staff to honor King with food drive

Friday, January 06, 2006

By Nancy Stier
MUSKEGON CHRONICLE CORRESPONDENT

Norton Shores residents are asked to search their pantries during the next week for items they can contribute to the food drive city staff will conduct for Mission for Area People in Muskegon Heights.

The food drive is city staff's way of honoring Martin Luther King Jr.'s birthday observed this year on Jan. 16.

The collection will run weekdays from 8 a.m. to 5 p.m. starting Monday and running through Jan. 17. Dry goods, canned goods and personal hygiene supplies can be dropped off during those hours at all Norton Shores City Departments scattered throughout the community.

This is apparently the first time city employees have staged this type of event for pantries serving low income people, according to Carrie Larks, director of administrative services.

City officials have been pressured by Muskegon Community Solidarity during the past few years to honor the slain civil rights leader, for whom there is a national holiday, by giving employees the day off.

Up to this point, city officials say staff has been unwilling to trade one of their existing personal days for time off on King's birthday. But they did select the food drive this year as a way of furthering King's dream of achieving racial justice and alleviating poverty.

Norton Shores City Council also passed a resolution this week in honor of King stating Jan. 16 is a "people's holiday" celebrating the values to which King dedicated his life and encouraging community service.

Larks said dry goods and canned goods will be accepted starting Monday through Jan. 17 at the city's three fire stations.

Tax help available for families with low incomes

Refunds return more than $5.9 million to region's economy

Friday, January 06, 2006

BY STEPHENIE KOEHN
Ann Arbor News Staff Reporter

Many low-income families qualify for tax credits and refunds, but often they are unsure how to fill out the forms.

The Oakland Livingston Human Service Agency and the Accounting Aid Society have joined forces to train volunteers to help low-income families prepare and file their income-tax returns.

Last year, more than 6,900 households in the metropolitan Detroit area, including Livingston County, received an average return of $849 per family, thanks to the program's 700 volunteer tax preparers. The refunds and credits were used to purchase necessities, including utility bills, rent and groceries. In all, tax volunteers assisted in the return of more than $5.9 million to the economy of southeastern Michigan, said Catherine Rea Dunning, executive director of OLHSA Livingston County.

Training for new and returning volunteers will take place from 6-10 p.m. Jan. 17 and 24 at the Cleary University Howell Campus, 3750 Cleary Drive, Genoa Township.

The sessions will teach volunteers how to prepare simple local, state and federal income tax returns for clients. Participants also will learn how to help clients file for credits such as the Home Heating Credit (which can help low-income families pay their rising energy bills); the child Tax Credit (which provides $1,000 per qualifying dependent 17 years of age and younger); the Homestead Property Tax credit (which renters also can receive); and the Earned Income Tax Credit (which can give a qualifying household a credit worth up to $4,400).

After training, volunteers can choose to help at locations in Livingston, Wayne, Oakland and Macomb counties. Volunteers also are needed to serve as site managers and greeters.

Once training is completed, tax preparers will be on hand to help qualifying Livingston County residents at the following times and sites:

10 a.m.-2 p.m. Saturdays, Jan. 28-March 4, at the Cleary University Howell Campus, 3750 Cleary College Drive, Genoa Township.

5-9 p.m. Tuesdays, March 7-April 11, at Livingston County Michigan Works at the M-TEC Center, 1240 Packard Drive, Howell Township.

For more details and to register, call Catherine Rea Dunning at (517) 546-8500.

Reach Stephenie Koehn at skoehn@livingstoncommunitynews.com or at (810) 844-2008.

Lansing State Journal

Letters

January 6, 2006

Support appreciated

On behalf of the more than 30,000 Ingham County children that we serve, the staff of the Ingham County Friend of the Court wishes to express their appreciation to Justice Maura Corrigan and to the LSJ for their support of continued federal funding of the many legislatively mandated programs and services that we provide for the benefit of those children.
These are economically challenging times - particularly for those in Michigan families who do not have adequate sources of support. The Friends of the Court of Michigan are committed to continue our efforts on their behalf.

Donald L. Reisig
deputy court administrator
Ingham County Friend of the Court
East Lansing

New estimates mean budget cutters may put scissors away

Thursday, January 05, 2006

By Peter Luke
Lansing Bureau

LANSING -- Mid-year state budget cuts could be averted as higher tax revenues and unspent funds have produced an unexpected surplus of nearly $320 million in Michigan's treasury.
The surplus from the fiscal year that ended Sept. 30 is a small fraction of the $20 billion budgeted this year for general state operations and public schools. But assuming revenue forecasts hold, the extra cash likely means there won't be mid-year budget cuts for the first time since 2001.
Still, state officials were guarded in their optimism.
"We do now effectively have money in reserve, but we're still in very uncertain economic times," Gary Olson, director of the Senate Fiscal Agency, said Wednesday.
Olson and other economic forecasters for the Legislature and Gov. Jennifer Granholm will meet next week to set revenue targets for the 2007 budget Granholm will present lawmakers in February.
Some of the surplus is already spoken for. Business tax cuts that took effect Sunday will cost between $60 million and $100 million in fiscal 2006. A House-passed measure pending in the Senate would ship about $35 million in additional education tax revenue to local schools.
Budget Director Mary Lannoye added Wednesday that anticipated cuts in federal aid and higher Medicaid health care caseloads mean that Michigan's budget is still tight.
The chief budget concern for fiscal years 2006 and 2007 is the state's troubled auto industry. While analysts say the state dodged major harm in General Motors Corp.'s downsizing plans, Michigan plant closures still could be announced by Ford Motor Co. and parts giant Delphi Corp.
Lannoye said given "serious financial uncertainties" in the manufacturing sector, potential federal budget cuts and large spending pressures in fiscal 2007, "we must continue to live within our means by continuing to show fiscal responsibility."
The state's general fund, a catch-all budget that funds prisons, colleges, health care and most state operations, was $220 million in the black, according to the final audit of the 2005 books by Lannoye's office. The larger school aid fund that pays for most of K-12 education had a 2005 year-end surplus of $98 million.
The business tax relief package approved last month carries a fiscal 2006 price tag in excess of $60 million. The main tax cut, benefiting manufacturers, is a Single Business Tax credit equal to 15 percent of property taxes paid on industrial personal property.
Since lawmakers declined to approve offsetting revenue increases on businesses, the tax cut will have to be paid out of the surplus. Small business groups are clamoring for tax relief for their members as well. Senate Majority Leader Ken Sikkema, R-Wyoming, has vowed to deliver it when lawmakers return to work this month.

Awaiting action in the Senate is a House-passed measure to distribute $35 million in anticipated surplus funds back to local schools: $49 in per-pupil funding hikes to boost middle school math and science education, and up to $18 per pupil in districts receiving less than $7,200 in per-student state aid.

A debate over how to disperse excess funds would be the first in a half-decade. The past several years have seen declines in state revenues that have forced have wrenching mid-year budget cuts in state aid to universities, local governments and health care providers.

Hotlines are great, if they're reliable

Editorial

Friday, January 06, 2006

In the old days, you might have answered your door and heard, "Hello, I'm from the government and I'm here to help you." These days, government extends its "helping hand" more typically by telephone hotlines. But alas, the help is not always reliable.

Last week, Knight Ridder Newspapers reported on an internal Veterans Administration memo that detailed dismal results of a 2004 mystery-caller program designed to evaluate the accuracy of advice given over the VA help line. VA experts made a total of about 1,000 calls to the agency's regional offices.

What the calls revealed is a startling level of inaccuracy. Nearly half of the time, callers got answers that the VA judged to be either entirely wrong or only minimally correct. Here are the percentages: Correct answers, 19 percent; mostly correct, 16 percent; partly correct, 20 percent; minimally correct, 23 percent; completely incorrect, 22 percent.

As unacceptable as those findings are for a federal agency, they are at least improved from 2002, when a mere 5 percent of the answers were found to be entirely correct.

Here's the gist of one mystery caller's conversation: Since the herbicide Agent Orange was widely used in Vietnam and many conditions have been linked to it, the caller asked about benefits for a Vietnam veteran who died of lung cancer. The response was that lung cancer is "not one of the conditions related to Agent Orange." The VA's evaluation: "Completely wrong," since lung cancer is in fact related to Agent Orange.

Possibly more dismaying was the VA's finding that many VA workers staffing the phones were rude, dismissive of callers' concerns or unhelpful.

The VA's experience should not be seen in isolation. In the past, we've learned of similar problems with the Internal Revenue Service help line. (This year, by the way, the IRS is trimming $100 million from its customer-service budget by cutting three hours of daily availability from its toll-free help lines.)

Also, as the new Medicare prescription-drug benefit takes effect, it is worth knowing that a report in December found, after making 420 calls to the 1-800-MEDICARE help line, that representatives answered the six test questions correctly 61 percent of the time. In other words, 39 percent of the time, the answers were wrong.

In 1994 the federal government established the American Customer Satisfaction Index (ACSI), partly with help from the University of Michigan. In 2005, the ACSI showed overall customer satisfaction with federal agencies was down 1.1 percent from 2004. Indeed, 43 percent of federal agencies saw a drop in customer satisfaction -- with the largest drops in regulatory agencies. The biggest overall decline -- a 3.8 percent drop in satisfaction among paper-return filers -- was recorded by the IRS.

So yes, the VA has some remedial work to do with staffers who answer the telephone and represent the agency to millions of Americans. But the problem goes well beyond the VA.

We all think of government as authoritative. And it may indeed speak in the authoritative tone of an IRS tax specialist, an EPA bureaucrat or **a Medicare hotline staffer**. However, an informed American will take these "authoritative" answers with caution. If the question is important, it pays to do your own homework.

--The Jackson Citizen Patriot

Letters for January 6

The Grand Rapids Press

Friday, January 06, 2006

Unjust welfare proposal

I find it interesting that my comments have become the source of public indignation rather than Rep. Jerry Kooiman's poorly thought through legislative revisions of our state's welfare regulations.

We should all be appalled that Mr. Kooiman attempted welfare revisions without extensive discussions in Grand Rapids with his constituents most affected.

He claimed publicly that he discussed the specific concerns of African Americans with Sen. Bill Hardiman, R-Kentwood, and other legislators from the Detroit area. Even if this was true, shouldn't it have occurred to both representatives to consult with the affected constituents?

Once confronted publicly by African American civic leaders about his miserly fact finding, Mr. Kooiman was then pressured to respond. At the meeting reported in The Press, there were both black and white people questioning his policy choices. When asked about the details of his legislative changes, Mr. Kooiman seemed unable to respond effectively.

To those present he had not done substantive preparation. Out of frustration, he began an ideological rant about "tough love" for those on welfare. Sloganeering is no substitute for sound policy making. What the representative seemed patently unaware of is that people on welfare are not children to be disciplined. If Mr. Kooiman had a smidgen of historical knowledge he would have known the type of paternalistic language he used has a bitter history for African Americans. To that I responded "as a white man don't speak to my people" in that manner.

Finally, I refuse to be apologetic about defending my ethnic community's interests in a city so deeply shaped by ethnic and family loyalties. It is more telling that some readers of The Press are more bothered by my utterance than welfare policies that are socially just. The real issue is not my comments, but my representative's poor consultative process in revising welfare legislation.

RANDAL MAURICE JELKS
Grand Rapids

Lansing State Journal

Letters

January 6, 2006

Target slackers

In response to Joseph Nemshak (Letters, Dec. 27):
If only welfare reform could be so easy. We, the taxpayers, should definitely continue to "reward" irresponsibility by financing the livelihoods of those unwilling to work. We should encourage more teen and un-wed pregnancies. We should let them scam their way out of mandatory work programs by letting them get on Social Security. We should buy them cars and new clothes, in the naive hope they might keep a job for more than a month.
We should fill their chest freezers with prime cuts of meat after a blackout. We should allow fathers of illegitimate children to skip out on child support while the taxpayers pick up the tab. Heavens, we wouldn't want welfare taken from "those who really need it." Especially if it is a daughter, niece or sister who might have to move back home, God forbid.

Anthony Garza
Lansing

Kalamazoo Gazette

Letters

January 6, 2006

He disagrees on benefits extension

An early example of the tenor of decision-making by newly installed Kalamazoo City Manager Ken Collard shows he isn't to be trusted by Kalamazoo citizens embracing family values and conservative thinking. Indeed, his action contains flagrant disregard of voters of the entire state. Over a year ago, the voters of Michigan said ``no" to municipalities who chose to give employment benefits to same-sex partners of their employees. Whether or not you agree that this living arrangement is right or wrong, Collard has begun his new career by extending those benefits for six more months, thus squandering not only precious city funds, but his own credibility as well.

State Attorney General Mike Cox issued an opinion based on the will of the voters. Kalamazoo citizens are correct to wonder what other cavalier choices are to come from a man who was chosen without wide review by city commissioners.

Tim Rogowski
Kalamazoo