State Health Watch

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Will an Obama administration get the federal-state partnership back on track?

Many state Medicaid directors say the federal-state partnership has never been worse, due in part to proposed regulations from the Centers for Medicare & Medicaid Services (CMS) that would shift costs to states. States report a lack of cooperation for virtually every aspect of the program, from waivers to state plan amendments.

According to Kentucky's Medicaid commissioner **Elizabeth Johnson**, "Kentucky feels no different than most other states — that the federal-state partnership is strained."

Ms. Johnson says the federal government is requiring more from state Medicaid programs, when there is already additional pressure due to the economic downturn. States are being required to take on more financial responsibility, she says, and state programs are being subjected to additional oversight, audits, and reporting requirements.

"Additionally, the most recent proposed regulations by CMS will place additional financial and administrative burdens on the states," says Ms. Johnson.

So will the new administration improve this situation for state Medicaid directors? "The hope is that

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Washington struggles to preserve core program while in 'survival' mode

Washington state currently is in "survival mode," struggling to preserve as much of its core state Medicaid program as possible, in the face of a staggering $5 billion shortfall.

Fiscal Fitness: How States Cope

Doug Porter, assistant secretary for medical assistance administration in Washington's Department of Social and Health Services, says there only are three ways to manage the cost of the program: rate structure, benefits, and eligibility.

"I've been given a target of about 20% for a reduction exercise," he says. "The first place I will go will be to manage the benefit design and try and control utilization better. I may even look at some optional services we've adopted, such as interpreter services, which we might have to scrap."

The second place Mr. Porter will go is rate increases. Last year, pediatricians were given a 48% rate hike, in recognition that the 1% or 2% vendor rate increases given over the last 10 years hadn't been adequate to keep up with inflation.

Eligibility is the last thing that

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In This Issue

Editor's note: This is a special issue of State Health Watch *on the expected impact of the Obama administration on state health care reform. Inside, we cover the future of the federal-state partnership, prospects for reauthorization of the State Children's Health Insurance Program, and what state Medicaid directors can expect to see with health information technology.*

State Health Watch
The Newsletter on State Health Care Reform

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New administration

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the change in administration will be a positive change," says **Edwin Park**, a senior fellow in the health policy department at the Center on Budget and Policy Priorities in Washington, DC. "Over the short term, the Obama administration has been working with leaders on the Hill on economic stimulus legislation."

Many states are hoping for a temporary increase in the federal Medicaid matching rates, which would allow them to absorb higher Medicaid enrollments, and also relieve the overall pressure on state budgets.

"States are facing deficits as revenues plummet," says Mr. Park. "With a temporary increase in the federal Medicaid matching rates, they will be able to avoiding making spending cuts or implementing tax increases, both of which would deepen the recession by scaling back state economic activity."

In the long run, he says, the hope is that there will be more support from the federal government to encourage states to take up health reform efforts and various expansions.

According to Medicaid spokeswoman, **Mary Kahn**, the Bush administration "has given states unprecedented flexibility in managing their Medicaid programs. The Deficit Reduction Act gives states freedom to redesign benefits packages to best meet the needs of their enrollees while keeping the program on sound financial footing."

Mr. Park says he expects that the incoming administration will quickly withdraw the Aug. 17 guidance that the Bush administration had issued, which essentially barred states from expanding their State Children's Health Insurance Programs (SCHIP) above 250% of the federal poverty level.

"And in other cases, the Bush administration has made it more difficult for states to expand, or encouraged them to expand, only in certain ways that the administration thought were preferable," says Mr. Park. "It's unclear what the specifics of the new administration will be, but I think they will be more interested in encouraging states instead of standing in the way."

One ongoing concern with the current administration was that one state would apply for a waiver and get certain favorable terms, while other states would apply for something similar and the rules of the game would not be the same. "I think there is some hope that there could be a more uniform treatment of states, as opposed to some states being treated differently than others," he says.

States need support now

Fiscal relief, however, is the "No. 1 focus" for state Medicaid directors who want to see an economic stimulus package enacted quickly, says Mr. Park. The hope is that the federal government will step in to provide additional support for state Medicaid programs, which are under a lot of stress.

"There are increasing signs that there will be significant midyear cuts, as well as cuts proposed for the upcoming state fiscal year, which usually starts on July 1. We are looking at deficits of well over $200 billion dollars, for both the current year 2009 and 2010, and even beyond," he reports. "A very large fiscal relief package is essential to preserve state services, including Medicaid."

Previous downturns have shown that even when an economy recovers, state budgets typically don't

come back into balance until well after the economic recovery is under way. "From a state budget perspective, it's a lagging indicator," says Mr. Park. "So, these budget deficits could be facing states for some time."

States were able to recover to some degree from the previous economic downturn and were able to invest in their rainy-day funds. "But many of those rainy-day funds have been drawn down, and one-time savings have been exhausted," he notes. "It is certainly not looking very good right now."

David S. Parrella, director of medical care administration for the Connecticut Department of Social Services, says that he would look for the Obama administration to work on some "quick victories in health care to build momentum for wider reform." These would include reauthorizing SCHIP with broad state flexibility, such as coverage of children up to 300% FPL, possibly lowering the eligibility age for Medicare from 65 to 55 to help the states with the cost of their aged, blind, and disabled population, and making noncategorical single adults Medicaid-eligible up to 100% of FPL.

"This last initiative would essentially 'buy out' our state-administered general assistance program and other state programs to cover the noncategorical population," he says. "These are some examples of how the federal government could relieve hard-pressed states and improve health care access and services for individuals."

Expansions on hold?

In 2007, states were taking "really unprecedented action to move forward" with expansion programs, according to **Robin Rudowitz**, a principal policy analyst for the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured. "It was the most advancement we had seen since the enactment of the SCHIP program."

Many states had proposals or were adopting new plans to expand coverage to reach additional uninsured. These ranged from proposals for large-scale health reform like California's, to targeting children, to efforts to simplify enrollment. "So, there were a whole host of efforts around that," she reports. "In 2008, states were still moving in that direction. But how far they can go to accomplish those goals and continue along that path has certainly been hindered by the current economic situation, for a lot of states."

Another factor is what will happen with SCHIP reauthorization. "Some states, like North Carolina, had passed legislation to expand that was somewhat contingent on additional dollars being available for SCHIP reauthorization," says Ms. Rudowitz. "There is a movement to get additional health care coverage, but we are not going to get there with every state taking their own action. You really do need some type of federal action to really get to something like universal coverage."

As for states taking steps toward universal coverage, Mr. Park says he thinks it's a "definite concern" as to whether they can go ahead with their plans. "Massachusetts is going ahead—they just got their waiver renewed, which helps fund their coverage plan. But a number of states interested in pursuing coverage might not do so because of budget problems," he says.

Mr. Park adds that some states may reconsider their larger, broader health reform plans in anticipation of potential federal action in 2009. "I think another factor is that a number of states had strongly considered or even enacted expansions for children's coverage, but a number of states were obstructed from moving forward because of President Bush's Aug. 17 guidance," he points out. "States were unable to get approval for expansions that their legislatures had enacted and their governors had signed into law. And that was *before* the budget shortfall started to get increasingly serious."

Over the longer term, Mr. Park says the way health reform is structured could bring down costs throughout the U.S. health care system. This, in turn, would bring savings to Medicaid programs in the states.

"If you adjust for health status, Medicaid actually costs less than private insurance for individuals. But what is really driving Medicaid costs is not necessarily enrollment, but overall health care costs throughout the U.S.," he explains. "If you have broader health reform that includes coverage expansion so you don't have cost shifts, as well as broader cost containment that would relieve pressure on state Medicaid programs, that could stabilize state budgets."

Mr. Park says cost containment, as well as achieving higher quality and expanding coverage, is an essential component of any reform effort. "We are spending more on a per-capita basis than other countries for the same quality, and in some cases for lower quality," he says. "States are already being economical, especially considering the populations that are served under Medicaid, which tend to be in much poorer health than the private insurance market. Tamping down health care costs in a smart way would relieve pressure on states."

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Fiscal Fitness

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will be cut. "We have been under direction from our legislature to expand up to 300% of the federal poverty level (FPL). It's going to be pretty darn hard to maintain that direction," he says. "We are in a survival mode here, trying to protect the core part of our program, rather than improving or expanding."

$5 billion shortfall

In previous economic downturns in 2003 and 2005, the state faced about $2 billion in shortfalls. "We are now approaching $5 billion, so it is a bigger projected shortfall, and undoubtedly a combination of a lot higher costs for Medicaid, long-term care, child welfare, and economic services," says Mr. Porter. "If you provide all the same services to all the same eligible categories over the next two years compared with the last two years, it will cost us over a billion dollars more."

Then, you need to factor in the decreased retail or real estate tax dollars coming in. "We're in a helluva fix here. And it will take some tough decisions before we find our way out of it," he notes.

The state was directed to expand eligibility for children up to 300% of the FPL, effective Jan. 1, 2008. "We are still in negotiations with CMS over that; they have yet to approve it. But now even if they did approve it, I would question whether we could afford to do it," says Mr. Porter.

Mr. Porter says his mission is to protect the core of the program. "What we are looking at are benefits," he says. One possibility: Enhanced mental health services for children, which became effective July 2008.

"We offered to double the number of visits we would pay for, and opened up the number of different providers who could bill us for mental health services," Mr. Porter says.

Previously, only psychiatrists in the state's fee-for-services program were eligible, but now any licensed mental health professional can become a Medicaid provider.

"I don't know that I can sustain that expansion of service. Those are the kind of benefits we are looking at in making reductions," says Mr. Porter. "We just started promoting our children's expansions—and now I'm not sure if we can sustain that."

As for provider rate cuts, Mr. Porter says providers may disagree, but he thinks the state has done a fairly good job of not cutting into provider rates. During the last session when revenue was good, primary care office visit rates for children were raised by 48% for some of the most frequently used codes, in response to a request from pediatricians to make up for lost time. He says he now has to look at reducing this "catch-up" payment.

"We may be looking at a time today in this budget go-round where provider rates have to be cut," Mr. Porter says, adding that he is asking himself the question: "If they got a 48% rate increase effective last January, how much of that can I take back and not lose access? Those are the kinds of questions we're having to ask ourselves."

Process is under way

The state is currently in the middle of budget preparation activities, which started back in September 2008 with an initiative titled "Priorities of Government." "We cluster our state spending into about a dozen buckets, one of which is health care," says Mr. Porter.

Mr. Porter, representing the Department of Social and Health Services (DSHS) and the Medicaid budget, sits down with the Department of Health and representatives of other state programs, including workers' compensation and state employee benefits. "We put on the board, in a ranked order, how we would build our respective programs from scratch if we were starting today, and used the estimates of what they will cost for the next two years," he says.

First, Mr. Porter listed required or mandatory clients or beneficiaries for Medicaid, and then the optional categories and benefit services. "Everything goes on the table. You don't just talk about cuts, you talk about anything you spend money on and hold it up against an allotment that the governor's office thinks is reasonable. Then you see what fits, what falls above the line and what doesn't," he explains. "And are they critical? Does the allotment have to be increased and funds taken from some other activity?"

That part of the process has been completed, which sets the stage for each department. Next, Mr. Porter sits down with child welfare, vocational rehabilitation, and economic services to prioritize everything that is done within his own department. "We look at the budget target, and we see what falls below the line with DSHS. I think it's fair to say that the revenue projected over the next two years is such that it will require some fairly significant reductions," he notes.

One of the main principles used to determine those reductions, says Mr. Porter, is: "Can we be better purchasers?"

"Some say up to 30% of medical expenditures are either unnecessary, or harmful. We have put on the table, as Medicare has done, not paying for 'never events,' changing utilization of prescription drugs, and moving further from brand name and toward more generic drugs,"

says Mr. Porter. "Every percentage point we can move that needle is something on the order of a $5 million savings to the state."

Even in the best of times, the state should do more to be better stewards and reduce the cost trend, he says. "But that is not going to get us to a budget target if we are talking in the hundreds of millions of dollars. We're going to have to go deeper than that."

The next area talked about is eliminating pilot programs, some of which may go on forever whether they work or not. "And even if they work, they may never get taken to scale statewide," says Mr. Porter. "So, we said, after we do our purchasing strategies, are there pilot programs out there that we should just pull the plug on? Are they relatively new additions to the program? Have they not demonstrated their worth yet? Or maybe we have no intention to expand them to other areas, so we will just get rid of them. That's the second level of cuts."

The third level of cuts is when it "really gets tough," he says. "We have a fairly rich benefits package. Should we scale back on that?"

The very last resort is to reduce eligibility. Before that, the state will reduce benefits or provider rates, to the extent that it won't cause an access problem. However, Mr. Porter notes that when California proposed an across-the-board 10% cut on rates to its providers, the courts took the state to task for not taking into account how it would affect the beneficiary getting access to services.

"So, it's somewhat cynical to say that we are going to maintain eligibility, but we are going to cut rates to providers back so far that none will take a Medicaid client into their practices," he points out. "Then you really haven't done the client any service."

Mr. Porter says he would be surprised if he didn't have to look at making cuts in all of those areas as this plays out. "That's how severe I think the challenge will be in the next two years." ■

What will happen with SCHIP reauthorization?

The congressional delay in reauthorizing the State Children's Health Insurance Program (SCHIP) has, frustratingly, caused states to put plans for covering additional children on hold until future funding is assured. What are state Medicaid directors likely to see going forward, in terms of reauthorization of SCHIP?

It's unclear how health reform efforts will play out, but there are indications that there will be a relatively quick reauthorization of the SCHIP program. "States very much like the stability and predictability of federal SCHIP funding levels that the vetoed bills would have provided, as opposed to what we have now, which is just a short-term extension," says **Edwin Park**, a senior fellow in the health policy department at the Center on Budget and Policy Priorities.

Trish Riley, director of the Governor's Office of Health Policy and Finance in Augusta, Maine, says that the fiscal environment for states "has changed dramatically as we waited out the Bush administration's resistance to a significant SCHIP reauthorization. The long-awaited reauthorization of SCHIP, if it includes new opportunities to reach higher-income children and their parents, will require state match—new funds that may not be available any longer."

Elizabeth Johnson, Kentucky Medicaid Commissioner, says Kentucky has decided to be proactive when it comes to children's health insurance coverage and not wait for reauthorization.

Through Governor Steve Beshear's KCHIP outreach program, Kentucky is actively enrolling additional eligible children in the program.

An estimated 60,000 eligible children aren't enrolled in KCHIP or Medicaid, so the state has set a goal of having 35,000 more children enrolled in KCHIP or Medicaid by 2011.

The outreach program consists of a new web site (www.kidshealth.ky.gov), easier enrollment, improved efforts to retain children currently enrolled, and significant education and outreach efforts. Here are some changes that were made:

- A face-to-face interview with a state caseworker no longer is a requirement to enroll. Prospective families can apply online, request an application over the phone, or send a mail-in request via postcard.
- An advertising/marketing campaign is under way as well, which incorporates print (fliers, brochures, postcards, and posters) and radio advertising.
- Training is being provided across the state to case workers, school resource center directors, and medical office managers to assist parents who want to enroll their child.

"This outreach effort will have an additional financial impact on Kentucky Medicaid's budget," Ms. Johnson acknowledges. "However, we are committed to enrolling all eligible children and seeing that they receive quality health care, as this is an investment in Kentucky's future."

Contact Ms. Johnson at (502) 564-4321. ■

Here is what state Medicaid directors would like to see

Like many states, Vermont has been "disappointed" with the support of the current federal administration for its health care reform efforts, says **Susan W. Besio**, PhD, director of health care reform for the Vermont Agency of Administration. Dr. Besio also is newly appointed as the state's Medicaid director.

"Specifically, given the flexibility promised in our 1115 Global Commitment Medicaid Waiver, we had expected that CMS [Centers for Medicare & Medicaid Services] would support federal participation in our new premium assistance program for adults up to 300% of the federal poverty level [FPL]," she says. However, CMS only agreed to participate up to 200% FPL, leaving the state to provide full support for the remaining premium assistance enrollees. Given the current economic situation, this puts the state-only funded premium assistance program for people between 200% and 300% FPL in jeopardy.

President-elect Obama's health care reform plan is very similar to the health care reform efforts being undertaken by Vermont, according to Dr. Besio. "Depending on the national economic environment, we are hopeful that his policies will enable more support for our reform efforts," she says.

Dr. Besio says she also is hopeful that the Obama administration will look to Vermont for examples of progressive health care reform initiatives, such as its Blueprint for Health program that integrates prevention, chronic care management, and payment reform to better support primary care and achieve better public health outcomes, and its focus on health information technology to improve quality of care and control health care costs.

Tom Dehner, state Medicaid director of Massachusetts, also is hopeful that some elements of the state's health care reform initiatives will serve as a model for federal reform. "We look forward to being helpful in that process however we can," he says.

Mr. Dehner says Massachusetts enjoys a "strong and productive" partnership with the U.S. Department of Health and Human Services and CMS in administering the state's Medicaid and waiver demonstration programs and other initiatives.

In particular, Mr. Dehner and Massachusetts Secretary of Health and Human Services (HHS) JudyAnn Bigby, MD, are in the process of finalizing an agreement in principle with CMS and HHS officials to renew the Massachusetts demonstration waiver for an additional three years. "The agreement will allow our successful health reform programs to continue at current eligibility and benefit levels," he reports.

With a strong waiver agreement in place for the next three years, Mr. Dehner says he doesn't anticipate the change in administration to have a significant, immediate effect on Massachusetts' programs.

A new approach is expected

According to **Trish Riley**, director of the Governor's Office of Health Policy and Finance in Augusta, ME, while the policy of the Bush administration was not always supportive of what the state wanted to do, she always found the staff at CMS to be of the "highest professional caliber and very good to work with."

However, Ms. Riley says the Bush administration has tended to support state flexibility in ways that seek to reduce benefits, pass more costs on to beneficiaries who are least able to afford them, and support block grants for Medicaid, which is "an abrogation of an important entitlement to health care."

"Through regulations, they have proposed dramatic changes in what Medicaid has historically funded," she says. "The question of what Medicaid should fund—and how—*is* legitimate, of course. But the relationship has been more top-down and ideologically driven than negotiated with the states, from my vantage point. States that share the administration's ideology may take a different view."

Ms. Riley says she expects a different approach from the Obama administration. She says she hopes to see a national reform agenda. But even if the determination is made to continue state experimentation, she anticipates the Obama administration will "use a clear set of guidelines and allow states to have flexibility against clear expectations and with clear accountability."

"And I would expect those experiments to be across the ideological spectrum, as long as beneficiaries are fully protected," says Ms. Riley. "The challenge of how much can be achieved in the current economic crisis is very real, however."

Particularly in light of the current economic crisis, Ms. Riley says she is looking for the Obama administration to take a system approach to reform and begin to address inefficiencies in the system.

"Medicaid operates within the broader health care environment, and as such, needs to be considered in that context. The U.S. spends twice what other nations spend, yet we don't cover everybody and don't get better health outcomes or quality. We do more, have more, use

more, and spend more but get less for the investment," says Ms. Riley.

Better coordination of Medicare and Medicaid, as huge payers, can help drive system reform and streamlining with consistent billing, rates, and quality metrics, she says.

"Specifically, I hope the administration will address a fundamental issue in Medicaid," says Ms. Riley. "As we have de-linked welfare from health care eligibility, many people on Medicaid work and have access to coverage in the workplace but cannot afford it."

It needs to be determined, she says: Who is responsible for their coverage? This may mean requiring employer dollars to be pooled to help fund Medicaid, or redesigning the premium assistance program to assure the resources of employer contributions and federal Medicaid funding are combined.

"All of those issues would help advance Maine's health reform, that is designed to make affordable, quality coverage available to all," says Ms. Riley. "The key issue is affordability of comprehensive coverage in an environment where, absent cost constraint, employers are shifting more costs to employees. That is creating a growing pool of seriously underinsured people. If you have cancer, it doesn't do much good to have $1,500 of coverage for chemotherapy that costs far, far more, unless you have a high-enough income to self-insure that risk."

For cuts, everything's on the table

Carol Steckel, MPH, commissioner of the Alabama Medicaid Agency, says Alabama has a "bare-bones" program, and the only optional eligible group covered is nursing home residents. Those individuals are eligible up to 300% of the FPL; but if this were cut to 100%, they would get a Miller Trust, and Medicaid still would cover them. Since new administrative staff members would have to be added in this case, the state wouldn't see any savings if their eligibility were reduced.

Ms. Steckel says she hasn't come up with any definitive recommendations for the governor yet, but that "there won't be anything off the table" when it comes to balancing the budget. "We have a few benefits for adults we could cut. We're in a position where we are going to have to look at absolutely everything," she says. "The problem is, during the previous downturn, we took all the easy cuts. So now the cuts that have to be made are much more difficult."

Ms. Steckel says if the new administration wants to make something happen that is efficient and focused on quality, it should look at what the states are doing. "If you want to see true health care innovation, it's been going on in the states."

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Will new administration clear the way for widespread HIT?

An infusion of federal investment to advance adoption of electronic medical records and electronic prescribing may give states greater ability to leverage their own resources for health information technology (HIT).

According to **Vernon K. Smith**, PhD, principal of Health Management Associates in Washington, DC, "the key to HIT is developing the infrastructure. It is something that government almost has to be involved in."

Dr. Smith says the Obama administration will "certainly be committed to developing the infrastructure, but this all will take a lot of time. Still, the direction is clearly toward greater use of IT in health care, in particular with information exchange, electronic health records [EHRs] and e-prescribing."

This will definitely help the entire health system work more efficiently, says Dr. Smith, and contribute to improvements in quality and patient safety. "It is hard to calculate ROI for HIT," he says. "It is like building roads. The benefits accrue over a long time and to many people, including a lot of people who didn't make the initial investment. However, the ultimate return benefits everyone."

Carol Steckel, MPH, Commissioner of the Alabama Medicaid Agency, says she is "very optimistic" about the new administration's focus on health care. "They seem to understand that HIT is a critical component, not only for efficiency and making us better at paying claims and providing services, but also the quality component—making sure we are paying for the right services and paying for better outcomes," says Ms. Steckel. "From everything that I'm reading and seeing and hearing, that is going to be a priority for President-elect Obama and HHS Secretary designee Daschle. And that is exciting."

Ms. Steckel says she is concerned, however, that additional funding for HIT include Medicaid as well as Medicare. "Alabama Medicaid has one of the electronic health record demo site grants from Medicare, but that leaves out the pediatricians,"

she says. "So it leaves out a large portion of the primary care providers that we need in the Medicaid program. If you look at all the physician incentives, all of that has happened on the Medicare side. We really need it to be on the Medicaid side also."

Though optimistic, Ms. Steckel says that she would caution President-Elect Obama, his team, and Congress that if they want states to invest in HIT, additional resources must be provided. "And I think it can be done in such a way that the federal government gets a return on its investment, just like the states would," she says. "When you are looking at your bare necessities, it's hard to spend a lot of time focusing on the future. But we are. We're trying."

Funding is biggest barrier

Many states currently are working to develop electronic health records, says **Ann Kohler**, director of health policy for the National Association of State Medicaid Directors in Washington DC. "I expect that there will be more under the new administration. We are seeing states expand their use of electronic health records or health IT for quality improvements. Medicaid directors are very supportive of this effort."

Wider adoption of electronic medical records, prescribing, and patient registries may give states a greater ability to conduct population health studies and monitoring, says **Lisa M. Duchon**, PhD, a senior consultant at Health Management Associates in Washington, DC.

"I think that as the efficiency of analyzing medical information over large populations vastly improves, we will see a continued push toward more physician organization and integrated systems of care, and payment reforms that lead us toward regional health care programs, if not a single payer," she says.

Dr. Duchon says she also thinks new technologies will continue to emerge that put people in charge of their own health monitoring and self-care. "I can envision a revolution in 'personal health technologies' that combine with personal e-health records and telemedicine to actually reduce overall sick care utilization and the unit costs of some types of care," she says. "We will be seeing more of these 'disruptive innovations' over the next decade."

Funding is the biggest impediment for states looking to implement HIT. "Alabama is not unique. All of us collectively are having to look at program cuts and reductions in our budgets," says Ms. Steckel. "But it's an essential need to invest in quality that looks at high-cost patients and improving their outcomes and lowering our costs, and prevention services. And all of that can be gotten through electronic health records."

Ms. Steckel says "there is a whole gamut of good things that can come from the investment in HIT," such as doctors having additional data on patients so better decisions can be made. "But the entry-level point is money and resources," she says. "The second issue is: How do you get all the stakeholders invested in making it happen in a state? And that's not an easy chore. I don't want to say that once you have all the money you need, everything flies through very quickly and easily. But it can be done."

Grant money 'primed the pump'

A number of states have joined the Multi-State Collaboration on Medicaid Health System Transformation to expand the use of health information exchange and electronic health records.

As a participant in the collaborative, Ms. Steckel says best practices have been shared from "whoever is ahead of the curve" on issues such as privacy, health information exchanges, decision support, and Medicaid fraud detection programs.

Alabama was one of the states that received a Medicaid Transformation Grant from the Centers for Medicare & Medicaid Services, to expand the use of technology to improve quality. "Part of the fun of being part of the collaborative is hearing how truly transformative those grants are for the states that got them, in helping the state agencies think differently, and putting the pieces of the puzzle together differently," says Ms. Steckel. "So, it's a very exciting initiative."

Alabama received $7.6 million dollars. "While that's a lot of money, in the world of HIT, it's not a huge amount of money," says Ms. Steckel. "And we have done phenomenal work with that money. We have gotten our stakeholders involved and invested in what we are doing. It 'primed the pump' is the best way of putting it, and got us ahead of the ballgame on EHR records. And I think you'd see that in a lot of other states, if it weren't for economic reality that we're dealing with."

Many states are "in the position of hanging on by our fingertips to our basic programs," says Ms. Steckel. "The 'luxury' of HIT gets put on the shelf for another day, unfortunately."

HIT can "take the way you've conducted business for the past 40 years and truly transform it," says Ms. Steckel. For example, in Alabama, eligibility always had been done the same way until about five years ago. A joint application was developed with Medicaid; the state's State Children's Health Insurance Program (SCHIP), which is run by the health department; and the state's Blue Cross/Blue Shield program, which covers children who are not eligible for either Medicaid or

SCHIP. A family member now only has to fill out one application to see if they're eligible for any of those three programs.

The application process can be started as soon as an individual gets on a computer in their library or home, up to the point where the applicant has to bring in his or her original birth certificate and citizenship and identity documents.

Also, since records are electronic, if an eligibility worker is out on leave, no one has to be moved into his or her physical location. "It's much more efficient. And our time for processing applications goes down. It's that type of thinking that we are starting to think of throughout the agency," says Ms. Steckel. "Everybody thinks about EHRs, but what we are doing in Alabama is EHRs and electronic clinical support tool and case management. Then the last piece is interoperability with other state agencies. But I think it goes much further than just those components. I have people thinking very differently than before we got the transformation grant. And there is the power of that."

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State legislation doesn't pass, but hospitals still act

As one of only a few states that require hospitals to provide charity care, Washington state has had a charity care law on the books since 1989. In 2006, the state legislature took another look at the issue.

"There was concern that although we did have a law on the books, it wasn't sufficient," says **Jonathan Seib**, a policy advisor to Governor Chris Gregoire in Olympia. "There was dismay over reports of what uninsured patients were being charged and the financial burdens that were being placed on people."

In the end, the legislation, which would have required hospitals to adhere to specific standards for charity care, didn't pass. However, the attention called to the issue achieved a very similar result. The state hospital association adopted, on a voluntary basis, a set of principles to guide its charity care.

The new voluntary guidelines cover uninsured patients up to 300% of the federal poverty level (FPL). All patients who document income at the FPL receive free care. Those who document income between 100% and 200% of FPL will not be asked to pay more than an amount representing the cost of care. All patients who document their income at between 200% and 300% of FPL also qualify for a discount and pay an amount no more than what an insured patient would pay.

There also is a provision requiring hospitals to increase their oversight of collection policy, and to provide information to patients about financial assistance.

"All that was done voluntarily in response to a big push to enhance the existing charity care law," says Mr. Seib. *(Editor's note: To see the State Hospital Association's charity policy, go to: http://www.wsha.org/files/62/Financial_Assistance_web.pdf.)*

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States expanding coverage of home, community-based care

States are shifting long-term services and dollars from nursing homes to care in the community, with 75% of states expanding coverage for home services, according to a recent survey by the Kaiser Family Foundation. As states look for ways to cut budgets, long-term care, which accounts for a third of all Medicaid spending, is one obvious possibility.

One way that states can delay use of nursing homes is by providing the home and community-based services as part of an integrated care plan that also provides all Medicare, Medicaid, acute, chronic, and long-term care services through a health plan that receives a capitated payment from the state Medicaid program and from Medicare as a special needs plan. "Longstanding demonstrations in Minnesota, Wisconsin, and Massachusetts have had favorable outcomes," says **Mary Kennedy**, director of Medicare programs for the Association for Community Affiliated Plans in Washington, DC.

"Unfortunately, states that face budget shortfalls often need immediate savings," she says. "Immediate savings in integrated programs come first to the Medicare program, because inappropriate hospitalizations are reduced once a care manager is helping the person maintain their functioning and avoid health crises."

Substantial savings to the state's nursing home budget does come, but later than the current budget year, notes Ms. Kennedy.

"These integrated programs also require careful planning and development of contracts incentives to rebalance spending directed toward the community," she explains. "This planning staff is often some of the

first administrative cuts, as a reduced state work force is redirected to the immediate crisis."

$452 saved per person

Wisconsin's Family Care program gives seniors and people with disabilities more choices about where they live, while giving them the supports and services they need to stay healthy and independent. Family Care helps frail elders and people with disabilities live in their homes and communities and stay independent for as long as possible.

"We have piloted Family Care for the past seven years, and we know a great deal about the people who will enroll and what they can be expected to cost," says **Stephanie Marquis**, spokeswoman for Wisconsin Department of Health and Family Services.

An independent assessment of the early results of the Family Care pilots, released in October 2007, showed that in 2003 and 2004, Family Care saved the Medicaid program $452 per person per month.

The report said those savings were achieved by keeping people out of institutions, such as nursing homes, keeping them healthier, and maintaining their level of functionality. "The report proved that providing the right care, at the right time, in the right place—usually at home—is very cost-effective," says Ms. Marquis.

In fiscal year 2009, Maryland Medicaid implemented two new home and community-based waivers. "The first was a conversion of a state plan medical day care service into a 1915(c) medical day care waiver," says **Susan J. Tucker**, executive director of the Offices of Health Services. "The second is a CMS demonstration project on community-based alternatives to psychiatric residential treatment facilities. We do not expect the economy to have a negative impact on these two waivers."

The Medical Day Care Services Waiver was implemented on July 1, 2008, and about 3,000 individuals are enrolled. In addition, Maryland Medicaid added medical day care as a service under most of its other Home and Community-Based Services (HCBS) waivers, including the older adults waiver, the living at home waiver, the two waivers targeted at developmentally disabled populations, the traumatic brain injury waiver, and the model waiver for medically fragile children. Maryland expects to implement the other waiver shortly after Jan. 1, 2009.

Program will expand

In 2007, Utah implemented a new 1915(c) waiver, bringing the state's total to six home and community-based services waivers. The waiver that started in 2007, the New Choices Waiver, was unique in that its specific purpose was to de-institutionalize Medicaid recipients who would otherwise be receiving services in nursing facilities. In order to be eligible for this waiver, an applicant must be a current resident of a nursing facility and must have lived there for 90 days or more.

"Originally, this waiver was only located along the Wasatch Front, the most densely populated area in Utah. But as of July 1, 2008, the waiver is now available statewide," says **Tonya Hales**, RN, director of the Utah Department of Health's Bureau of Long Term Care, Division of Health Care Financing. "Due to this service being newly available in all areas of the state, we do anticipate this will result in expansion of the program over fiscal year 2009. We served 648 people in fiscal year 2008, and have available slots of up to 1,000 participants going forward."

Programs such as the New Choices Waiver and other HCBS programs have resulted in clients having additional choices about the setting in which they receive long-term care services. "The New Choices Waiver and our other waiver programs are assisting the state to have a more balanced approach to the provision of long-term care services," she reports.

For example, on July 31, 2008, 2,938 Medicaid clients were receiving services in nursing facilities across the state. At that same time, 520 Medicaid clients were being served by the New Choices Waiver. "Without the existence of the New Choices Waiver, these 520 individuals would have continued to reside in nursing facilities rather than in community-based settings," says Ms. Hales.

Although the report on total expenditures for FY 2008 is not

complete, preliminary numbers show that the average daily rate for nursing facility services is $151.68, while the average daily rate paid for the New Choices Waiver Program was $74.33 per day.

"We are continuing to look for opportunities to provide more balance between facility-based and home and community-based care," says Ms. Hales.

Currently, Utah is discussing whether the use of Section 1915(j) of the Social Security Act (authorized by the Deficit Reduction Act), which allows self-directed personal care to be provided as a state plan service, might be a mechanism to improve choice for participants and assist in addressing the shortage of direct care service providers.

"This is a small-scale program but is something that we believe addresses chronic care needs of individuals, who without the assistance at home, may need to seek facility-based care," says Ms. Hales.

Utah also is making efforts to "right-size" the number of nursing facility beds. "Currently, Utah's average daily census in nursing facilities is about 68% occupancy. We are looking at what other states have done to assist in taking some of their nursing facility beds off-line," she explains. "There are no specific plans under way on how to address this, but it's something we're trying to better educate ourselves about."

Ms. Hales says she doesn't anticipate the downturn in the economy will have an impact on the New Choices Waiver. "Because people are only allowed into the program if Medicaid is already paying for them in a nursing facility, we know that this program saves the state money," she says. "As far as starting any new initiatives, the economy will definitely have an effect on our ability to get funding."

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Billions could be saved by integrating 'dual-eligibles'

States can save billions of dollars by placing the "dual-eligible" population in an integrated setting with managed care organizations responsible for coordinating all services, according to a new report written by The Lewin Group and sponsored by the Association for Community Affiliated Plans and Medicaid Health Plans of America.

The report, *Increasing Use of the Capitated Model for Dual-Eligibles: Cost Savings Estimates and Public Policy Opportunities,* says approximately 8 million Americans are simultaneously covered by Medicare and Medicaid. These individuals account for about 40% of the nation's Medicaid spending and about 25% of Medicare expenditures.

While demonstrations in Minnesota, Massachusetts, Wisconsin, Kentucky, Texas, and Arizona have served people well, most dual-eligibles remain in uncoordinated fee-for service models.

Dual-eligibles typically have multiple chronic conditions that may be best served by a coordinated approach to their health and psychosocial needs, says the report. Currently, beneficiaries are forced to navigate the Medicaid and Medicare systems separately, which is not cost-effective. Here are key findings:

• For the five-year period from 2010-2014, the potential savings are almost $50 billion.

• An additional savings of $96 billion is possible for the five-year period of 2015-2019 and another $155 billion for the five-year period from 2020-2024.

• Even small increases in integrated care can help offset what might otherwise be program cuts that reduce eligibility, covered services, or reimbursement. Each percentage point reduction over the 15-year period saves more than $70 billion dollars.

The researchers argue that states should be permitted to enroll all dual-eligibles in targeted counties into a coordinated care setting, and to share 50/50 with the federal government in the net savings that occur across the Medicare and Medicaid programs. ■

Projects aim to reduce visits to EDs during peak volumes

In April 2008, the state of Colorado was awarded $1,816,199 by the Centers for Medicare & Medicaid Services for two projects designed to reduce the use of hospital emergency departments. In Colorado Springs, patients who request nonemergency services during evening and weekend hours at Memorial Hospital are being provided with referrals, education, and transportation vouchers to clinics. The hope is that the clinics will become a "medical home" for these patients, so they can receive ongoing preventive care.

The second project involves expanding clinic space and offering patients extended hours at Valley-Wide Health Systems in the San Luis Valley, during periods of peak volume at local hospital emergency departments.

The projects will enable Colorado Medicaid to more effectively meet the preventive health care needs of its Medicaid population and to reduce health care costs for the state, according to **Sandeep Wadhwa**, MD, Medicaid director and chief medical officer with the Colorado Department of Health Care Policy and Financing.

"There's a shortage of primary care providers in Colorado; particularly in our rural areas," he notes. "Our Community Health Centers provide a critically important source of primary care."

Primary care providers are being supported with provider rate increases, and Colorado also has implemented a Medical Home pilot to expand primary care participation and access to care. "We also know that this will improve continuity of care and health outcomes," Dr. Wadhwa adds. ■

The technology factor: Is it our friend or foe?

While The Joint Commission is asking health care facilities to use computerized physician order entry and bar coding technology as an adjunct to arm themselves in managing high-risk medications including anticoagulants, a recent study highlights the errors implicit in this kind of information technology (IT) support.

Peter Angood, MD, vice president and chief patient safety officer for The Joint Commission, points out that while technology is helpful, it is not a panacea. "The expectation is that technology will solve the problem," he says. "And it does not."

A first-of-its kind study tackles the problems inherent in IT systems often praised and recommended as first-line defense against medication errors. The study examining flaws in bar code medication administration (BCMA) systems was published in the July/August issue of the *Journal of the American Medical Information Association*.

Led by **Ross Koppel**, PhD, lecturer/adjunct professor in the department of sociology at the University of Pennsylvania, researchers looked at five hospitals in the Midwest and on the East Coast and found 15 types of workarounds in which clinicians overrode the BCMA system to compensate for difficulties in the system.

One of the major findings, Dr. Koppel says, is "contrary to what is ordinarily discussed in the literature." In the study, he says, about 11% of medication bar codes were unreadable.

For the complete article, see the AHC Media LLC publication Healthcare Benchmarks and Quality Improvement, *December 2008 issue , at www.ahcmedia.com.* ■