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Tight state budgets slowing pace of Medicaid cost-containment initiatives

Even in good economic times, Medicaid directors have limited resources to do all that recipients, families, providers, legislators and taxpayers expect of them. "With a possibly long recession on the horizon, their ability to manage competing interests—limiting expenditures, expanding access to health care for children and families, and serving as the insurer of last resort for society's most vulnerable—is even more challenging," says **Lisa M. Duchon**, PhD, a senior consultant at Health Management Associates in Washington, DC.

The financial pressures on Medicaid and State Children's Health Insurance Programs (SCHIPs) mean that state Medicaid directors need to know which cost-containment programs really work.

"Much of the health care world—insurers, providers, employers, and states—is now focused on cost containment, in recognition of the reality that we must 'bend the curve' of health care cost trends if we are to keep even the level of access and coverage we have today," says **Robert W. Seifert**, senior associate at the Center for Health Law and Economics at University of Massachusetts Medical School in Charlestown.

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Arizona's Medicaid program awaits budget cuts; is in 'uncharted territory'

When Arizona received its Medicaid Transformation Grant in 2007, "we had a budget surplus," says **Anthony Rodgers**, director of the state of Arizona Medicaid/SCHIP programs, known as the Arizona Health Care Cost-Containment System. "And within the first three months of 2007, the bubble burst in the housing market—it was the fastest negative economic downturn I've ever seen. In terms of our tax revenues coming into the state, they just kept dropping like the stock market dropped. Normally, you can forecast a slow trend downward in advance, but what we experienced was like going over a financial cliff, just straight down," he says.

Fiscal Fitness: How States Cope

As it turned out, the state's plummeting revenues were just the first problem to affect the Medicaid budget. "That just meant there were less state general fund dollars. But that was just the first of the economic consequences experienced by the state. What really started to create significant budget problems was that our caseload started to skyrocket," says Mr. Rodgers. "So, it was a double-whammy between not having the

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Cost containment

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Many tools and approaches to systemic cost containment are available, but few offer the short-term solutions that state budgets need. "In fact, they may even require short-term investment, such as for the extension of health information technology, which would yield benefits over time," Mr. Seifert says.

Dr. Duchon says there is growing awareness that reducing the rate of growth in health care spending goes well beyond the medical care system, and this involves not only public health leadership, but also participation from departments of education, environment and natural resources, transportation, and housing at state and local levels.

"We are still early on, with states looking at different approaches," says Dr. Duchon. She predicts there will be growing interest in care coordination and patient involvement, to identify people at risk and keep them out of the hospital.

President Obama's health platform and the health reform legislation Sen. Max Baucus (D-MT) are promoting both include the creation of a new, national comparative effectiveness institute. Dr. Duchon also notes that this past year, Massachusetts passed legislation that requires the state to file a report by March 30, 2009, that compares the effectiveness of medical procedures, prescription drugs, and medical devices based on existing models of comparative research in Great Britain.

"So, we could see more action like that in other states, although I think this is something that should be undertaken at the federal level," says Dr. Duchon. "We're all waiting to see whether a really bad economy creates an imperative for passing national health care reforms that expand coverage and make health care more cost-effective, or keeps them on the back burner."

Not much concrete evidence

Part of the problem is that there still is much uncertainty about what constitutes cost-effective care. "It seems every few weeks or so, we hear that something considered to be a 'best practice' is not actually supported by the latest medical evidence," says Dr. Duchon.

In terms of the kind of information that states need in order to make purchasing decisions, that "is really just getting started," says Mr. Seifert.

"The one area that Medicaid is actually fairly advanced in is drug purchasing," says Mr. Seifert. "That is one area where the clinical effectiveness evidence is being used to good effect." He points to the Drug Effectiveness Review Project, a collaboration with 14 member states that provides evidence-based reviews of the comparative effectiveness and safety of drugs in many widely used drug classes: (www.ohsu.edu/drug effectiveness).

"Part D probably helped more than anything in controlling Medicaid drug costs, because it took a lot of the more expensive drug purchases out of Medicaid and put them in Medicare," says Mr. Seifert. "Also, a lot of states have preferred drug lists that are based on evidence of effectiveness. That has helped control spending in the drug area for a lot of state Medicaid programs in the last five to seven years."

Other than that, there are some pay-for-performance initiatives that are trying to tie payment to quality or value. "But they are pretty small and unproven at this point," says Mr. Seifert. "I think that everybody acknowledges that we need to move in this direction. But there isn't a lot

there yet, as far as I know."

The argument for cost-savings resulting from prevention initiatives is, overall, less compelling, but the Medicaid population may be an exception, according to Mr. Seifert. "There is less evidence that prevention is a real money-saver. But, Medicaid may be a group that hasn't had the regular care for chronic conditions like asthma or diabetes. If you then start giving it to them, I think you can realize some significant savings from avoided hospitalizations. If you can keep people out of emergency departments by teaching them home management of their diabetes, that could probably pay for itself."

One irony is that Medicaid programs are "sitting on huge amounts of claims and utilization data that would really go a long way toward making more value-based purchasing," says Mr. Seifert. "But a lot of states don't really have the wherewithal to do that type of analysis and turn it into policy decisions, or buy the services to do that sort of analysis. A lot of Medicaid programs, especially now, don't really have the luxury to analyze the data that they have to tailor their programs in a way that would result in better value."

Scarce resources are being directed toward running a Medicaid program, as opposed to doing long-term research on high-cost members and what kind of services they are using to craft a disease management program. "A lot of the medical home discussion revolves around specific subpopulations that are really the high-cost people," says Mr. Seifert. "If you could manage their care in a more deliberate way, you could probably be much more efficient in how you are spending for care for those people."

Pace of progress may slow

"This is something that states are going to continue to work on, even with the budget issues. It creates more of an imperative to work with managed care organizations to figure out who really needs close attention," says Dr. Duchon. "It goes back to that same old statistic that 80% of money gets spent on 20% of patients."

However, the reality is that for many states, the recession means that cost-effective initiatives will be slowed. "They may need to adopt them at a slower pace that their budget can afford," says **Jonathan Seib**, a policy advisor to Gov. Chris Gregoire in Washington state.

States are adopting strategies they've used over the past several years to limit spending, such as controlling drug costs, freezing or reducing provider payments, restricting eligibility, or reducing benefits.

"Thus, tight state budgets may slow or even reverse the pace of efforts to improve quality and coverage," says Dr. Duchon. "But they also generate pressure for more collaboration and partnership among purchasers, state agencies, contractors, and providers to improve the cost-effectiveness of care."

States that already have implemented cost-containment initiatives, such as care management programs, might be looking at expanding them to see additional savings.

"The budget situations now really make it imperative to try to do these kinds of things," says Mr. Seifert. "I think the states that have already begun to do care management would think about expanding that, in order to realize the savings."

Medicaid, he says, is doing what it is supposed to do in tough economic times—expand. "It's supposed to be there as a safety net for people who lose their jobs—that's what Medicaid is. But because Medicaid is such a substantial part of most state budgets, that is where the budget people look to realize some savings," says Mr. Seifert. "Nobody really wants to cut the programs or cut eligibility, which is shooting yourself in the foot anyway, because you lose federal revenue while you are trying to save."

Instead, cost-containment initiatives that lead to smarter purchasing may be cut instead. "Most of these things take some time to see any savings at all. That is the challenge. If states have to save money this year—and they do, because every state has to balance its budget—how do you do that within Medicaid when really, most of the significant savings you can realize are a multi-year sort of endeavor?" says Mr. Seifert.

If a state starts a cost-containment initiative now, "it's not going to get them very far in fiscal '09," says Mr. Seifert. "States that already have it started can build on it and add additional populations. Those states are probably ahead of the game. But that doesn't mean that everybody isn't under the gun."

This year, the attention of most state Medicaid directors is on a more immediate problem: They are hoping for some federal help to manage their increasing case loads and the costs that go with them.

"Longer term, I think cost containment will probably concentrate the minds of some Medicaid directors," says Mr. Seifert. "But anything that starts up right now isn't going to result in any savings for this year and probably the next. Each state is making its own decisions about where it wants to allocate its scarce resources."

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Fiscal Fitness

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tax revenues coming into the state coffers, and the enrollment going up so dramatically."

The state budgeted for a 3% increase in Medicaid enrollment in 2008, but over the last four months, enrollment has increased by 7%. Mr. Rodgers estimates that over the next six months, Medicaid enrollment could increase as much as 11%.

It didn't help that a significant percentage of Arizona's state revenues are dependent on the housing and construction industry. "But even when revenues started slowing down dramatically, it didn't really translate into additional Medicaid enrollment coming in, until the state's unemployment rates began to increase, which didn't start to go up until the later part of 2007," says Mr. Rodgers. "So, initially, it was just a revenue shock. Now, we have the tax revenue losses *and* the dramatic increase in enrollment."

Arizona is "one of the states that has been really impacted by the recession," according to Mr. Rodgers. "Right now, we are estimating that we will have over $3 billion revenue shortfall the next two years — an estimated $1 billion this year and $2 billion next year. We are in uncharted territory, because we have never had this level of revenue shortfall or potential budget deficit before."

Mr. Rodgers says he is hopeful that the federal government will increase the percentage of dollars it's paying into Medicaid programs as part of a proposed economic stimulus package, which would give the state some significant relief.

"We are also hopeful that the federal government will provide the next round of Medicaid Transformation grants," says Mr. Rodgers. "It may be a problem for us to continue our health information exchange operations much past July 2009 if we don't get additional dollars, because we won't have the necessary funds to maintain the project's operation."

He says the state is in such a tight budget situation, there are no additional dollars for operations for its electronic health record and health information exchange project initiative. "Although there is a lot of excitement about our Arizona Medical Information Exchange project, and it's getting a lot of buzz from providers, continued operations will depend on the overall funding of the Medicaid program and whether drastic cuts will be necessary."

The Arizona state legislature hasn't yet determined what specific cuts will be made. "Therein lies the dilemma," says Mr. Rodgers. "The legislature has talked about deficit reduction options but hasn't made any final decisions. We have submitted a list of possible cuts, but none of those have been enacted yet. We are waiting for the legislature to give some indication of where the program cuts are going to be required. Our HIT initiatives may have to be one of those program cuts."

There are ways for the state to cover its current deficit, but it would mean borrowing against future revenues and hoping the stimulus package will be large enough to kick start the economy again. "Some in the legislature don't feel the state should be borrowing against future tax revenues to cover current budget deficits," says Mr. Rodgers. "If that is not an option, that state has to come up with the cash now to balance the budget. And where do you get the cuts that will give you enough cash?"

Mr. Rodgers tells his staff to "wait until we see where the legislature makes its program cuts before you start personnel decisions. Until then, we can't decide what the future for our HIT initiative is and what we will need in terms of project changes."

The legislature has very limited options, notes Mr. Rodgers—they could eliminate or reduce discretionary programs such as the SCHIP program, because it is not an entitlement such as Medicaid. "But if they do that, they will make a lot of children uninsured, and that goes against the progress that has been made in reducing the number of uninsured children in the state."

The legislature also is evaluating reduction of some Medicaid benefits, such as nonemergent transportation or reducing the months a person is guaranteed Medicaid eligibility without reapplying. "So, unless there is an influx of additional federal dollars and the economy starts to pick up, we have some significant budget problems to overcome," says Mr. Rodgers. "The legislature will have make some very difficult program decisions." ■

States 'bend the trend' in Medicaid spending growth

According to **Emma Forkner**, South Carolina's state Medicaid director, "ensuring Medicaid programs are efficient and cost-effective should be a paramount concern to anyone who receives Medicaid or pays taxes, particularly when state resources are stretched as thinly as they are now."

She says it's important to point out that "cost-effectiveness isn't synonymous with skimping on services." The goal, she says, is to ensure you get the highest possible value out of every dollar you spend, which translates into better-quality services for Medicaid beneficiaries.

Increasingly, states are investing in care management and "medical home" programs to better coordinate health services for high-cost patients

as a way to "bend the trend" in Medicaid spending growth, says **Lisa M. Duchon**, PhD, a senior consultant at Health Management Associates in Washington, DC.

For example, Medicaid managed care and Primary Care Case Management (PCCM) programs are adopting various kinds of health risk assessments to identify high-risk or high-cost enrollees to get them into intensive case management services that could avoid future hospitalizations, ED visits, or uncoordinated specialty care.

Interest is building around bundling of payments that promote integrated, coordinated systems of care, often referred to as "clinically accountable organizations." These could include coordinated specialty-group practices, a hospital-centered network, and other integrated systems, says Dr. Duchon.

The Centers for Medicare & Medicaid Services (CMS) has taken an interest in how to encourage better collaboration in treating patients with complex illnesses. "To the extent that CMS experiments with payment approaches, Medicaid programs may see opportunities to do the same," she says.

Here are some initiatives states are implementing to make smarter purchasing decisions:

• Pay for-performance (P4P) incentives.

As more Medicaid programs and health plans are using P4P in care management or disease management programs, concerns are growing about how to attribute—and reward—positive clinical outcomes of patient care across a continuum of providers, says Dr. Duchon.

"Our systems of health care reimbursement aren't really set up to do that, particularly if care is provided through a health plan's provider network rather than an integrated health care delivery system," she explains. "In fact, the use of performance incentives to promote patient-centered care is helping to make the case for broader payment reform."

P4P just isn't a strong enough "signal" to overcome the disincentives in current reimbursement systems, Dr. Duchon explains. "More health care purchasers and researchers are viewing P4P as part of a transition to broader payment reform," she says.

In 2008, South Carolina initiated a program called Healthy Connections Choices, which encourages beneficiaries to choose between a variety of medical home options, including one of several managed care plans or a PCCM model. "This will ultimately give us the ability to gauge plan effectiveness and move to a pay-for-performance system," says Ms. Forkner. "People tend to think the Medicaid managed care movement is all about saving money. It's not."

The true benefit, if the program is structured correctly, is a focus on quality and health outcomes that cannot be achieved under fee-for-service Medicaid, says Ms. Forkner. "That's where we hope to be once our program is fully implemented," she says.

• Web-based access to claims history.

In South Carolina, a free statewide web-based provider tool, South Carolina Health Information Exchange, was launched. Physicians can instantly access eight years worth of a Medicaid beneficiary's claims history, including drugs prescribed to them. "This will lead to fewer unnecessary tests, reduced contraindications, and better communication among providers," says Ms. Forkner. "I'm hopeful new technologies like this will help solve some of the lingering problems we see in the health care industry."

• Incentives within managed care organizations.

Jason Helgerson, Wisconsin's Medicaid director says, "We have found that our members receive the most cost-effective care through managed care organizations. We believe that better-aligned incentives within managed care, including direct financial incentives, lead managed care organizations to keep people healthy and lower health care costs."

By receiving care through managed care organizations, members are able to establish a medical home and have their primary and preventive care managed. The state is facing a $5.4 billion shortfall, but since establishing a medical home for Medicaid clients is an integral part of the state's BadgerCare Plus program, this initiative will not be affected by any budget cuts. "We are always looking for ideas for cost containment. In a budget environment like this, it would only expedite cost-containment initiatives, not hold them back," says Mr. Helgerson.

• Prevention.

States are getting much better at identifying prevention programs that lead to results and those that may not, according to **Jonathan Seib**, advisor to Gov. Chris Gregoire in Washington state. "Evidence-based practices extend to public health as well. In budgeting, what matters is the cost. But what we are less able to capture is the ROI," he says.

The savings are significant—"but it may be a ways down the line," says Mr. Seib. "If, as a result of a state program, I don't pick up smoking, the time lag between when I otherwise would have gotten sick could be decades. It is sometimes difficult to measure the economic impact of prevention programs and public health programs, but we know they are real," he says. "We know not only does it benefit the health of people in Washington state that we have a tobacco cessation program, but in the end, we pay less for tobacco-related illness." ■

States report big savings with care management

According to a November 2008 report from Washington, DC-based Health Management Associates, targeted, highly customized interventions for people with chronic diseases can be an effective tool for reducing hospital readmissions.

The report, *Chronic Disease Management: Evidence of Predictable Savings*, highlights recent efforts in the Indiana and North Carolina Medicaid programs to implement targeted care management programs and reduce inappropriate utilization. Indiana's Care Select program was created in November 2007 to provide care management services to high-risk people via medical homes. The Community Care of North Carolina (CCNC) care management program was launched in 1998, with primary care physicians, local hospitals, local health departments, and the Department of Social Services identifying high-risk people with chronic diseases.

When age-adjusted Medicaid claims data were used to compare enrollees in the regular primary care case management program (the control group) with those getting enhanced care management via the CCNC program's provider networks, annual cost savings in asthma were $294,000 in the first year, $1.4 million in the second year, and $1.58 million in the third year. There were 23% fewer hospital admissions in the first year. Children had 34% fewer ED visits and 42.5% fewer asthma-related ED visits.

Here are some key findings in the report:

• Return on investment (ROI) for congestive heart failure (CHF) ranges from 4.8 cents to 32.7 cents per dollar invested. Care management for high-risk pregnancies yields reductions in neonatal intensive care unit use ranging from 37% to 62%.

• Among targeted CHF populations, the decline in hospital admissions ranges from 21% to 48%. For asthma/chronic obstructive pulmonary disease patients, the decline in hospital admissions or readmissions ranges from 11% to 60%.

Iowa's Medicaid program "prides itself on being an effective and prudent purchaser of health care services," says **Jennifer Vermeer**, director of Iowa Medicaid Enterprise. She says her program has accomplished this with these initiatives:

• The development and implementation of utilization management programs for medical and pharmacy services, including prior authorization and care management programs.

• Care management services provided for members with chronic conditions, including congestive heart failure, diabetes, and asthma.

"Evaluation of care management programs find a reduction in hospitalizations and inappropriate utilization of services, resulting in substantial savings of inpatient charges due to reduced health care utilization," says Ms. Vermeer. "A high percentage of program participants indicated satisfaction with the program."

Iowa Medicaid monitors health care spending by tracking costs over a five-year period and analyzing diagnosis codes, procedure codes, provider types, service units, and total expenditures.

"This data capture trends in service delivery, which are used to identify and implement cost containment and quality improvement initiative," says Ms. Vermeer.

According to **Cheryl Roberts**, deputy director of the Department of Medical Assistance Services (DMAS), "Management of asthma medication is a key factor for preventing asthma-related hospitalizations." Audited data from Virginia's Medicaid managed care organizations show that more than 90% of members with asthma adhere to important medication management guidelines.

Through a partnership with a disease management program, DMAS contracts with Richmond, VA-based Health Management Corp. to provide condition management resources to eligible Virginians with chronic diseases, such as asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease.

"When these conditions are managed effectively through a person-centered approach, it leads to improved use of disease management services and reductions in the use of preventable emergency high-cost services," says Ms. Roberts. "This program has demonstrated a 2-to-1 savings." ■

Be ready to make decision on how you'll invest in HIT

Due to a much-anticipated infusion of federal investment in health information technology (HIT), state Medicaid programs could possibly be getting a push forward for initiatives such as electronic medical records (EMRs) and electronic prescribing.

"The interest in this, because of the fact that so many people are now in Medicaid and also SCHIP programs, has really started to peak," according to **Anthony Rodgers**, director of the state of Arizona Medicaid/SCHIP programs, known as the Arizona Health Care Cost Containment System (AHCCCS). Mr. Rodgers is chair

of the National Association of State Medicaid Directors Multi-State Collaboration for Medicaid Transformation.

"There is recognition that e-records, e-prescribing, and the ability to exchange information among different health care providers would have great impact in reducing costs in Medicaid," says Mr. Rodgers.

Two years ago, Congress appropriated $150 million to state Medicaid agencies for various "transformation" projects. A number of states used the money to move forward with HIT initiatives, including e-prescribing, the development and deployment of electronic health records, and decision support applications to help with clinical decision making, as well as fraud and abuse detection.

However, the evidence of resulting cost savings is just starting to accumulate. "The initial projects will probably start to show return on investment in about a year," says Mr. Rodgers. "Most of the projects are just now getting implemented and becoming operational."

He says this is the reason the Multi-State Collaboration was created—so that other states can learn from Arizona's experiences and move forward more rapidly.

For example, Arizona is using its Medicaid Transformation Grant to develop and implement a web-based health information exchange to give all Medicaid providers instant access to patients' health information at the point of service. Arizona received a total of $11.7 million in federal funds to develop the Arizona Medical Information Exchange.

As part of an initial proof of concept, the Arizona Medical Information Exchange project team is evaluating the cost savings seen by about 60 providers who now can get access to health information, such as discharge summaries from hospitals, patient medication lists, and laboratory information.

"We have had a lot of positive feedback from providers, who say they were never before able to get this information in a timely manner," says Mr. Rodgers. "This is really making it possible for them to improve patient safety, quality of care, and reduce cost. We don't have a large enough group of users to have a huge cost savings with our current rollout. But it will give us the justification for scaling it up to a much broader group of users in the future."

Medicaid directors are key

"I believe that to develop a 21st century Medicaid health care system, you have to have Medicaid leadership that understands how to develop and deploy health information technology within the Medicaid program," says Mr. Rodgers. "That is a leadership skill that is required if you are going to bring your program into the 21st century."

With budget cuts, states are clearly in less of a financial position to aggressively move forward with a statewide HIT initiative. But, the Obama administration has said that investing in HIT is a high priority as part of an economic stimulus package.

"We are hoping that the federal government will provide states with additional funding to move forward with these kinds of initiatives," says Mr. Rodgers. "The federal government realizes that as a partner in Medicaid, they would benefit from any savings, too, if states achieve widespread adoption of electronic health records."

"I think the federal government is in a better position right now to fund these initiatives. Down the road as our economy turns around, states will be in a better position to then pick up the operational and maintenance costs of these HIT projects," says Mr. Rodgers.

There are some "front-runner" states, including Arizona, Alabama, California, New York, Georgia, Vermont, West Virginia, Texas, and Tennessee, which have aggressively moved forward with HIT for their Medicaid programs, but by and large, most states are taking a "wait-and-see" approach. "I think there are a number of states that are waiting to see what we are able to achieve and how we do it, before they will be comfortable making a commitment to HIT," says Mr. Rodgers. "And that's not unusual in Medicaid. We look to front-runner states to test out things before everybody else jumps in. But I do hear a lot of interest from states about moving forward with their own HIT initiatives. The biggest problem remains how to finance it."

Evaluate before moving forward

Simply because something is the "latest-and-greatest" technology, doesn't mean it is the most cost-effective solution for a specific Medicaid program. State Medicaid directors need to determine how emerging health information technology will affect the bottom line and decide whether the investment is "worth it."

State Medicaid directors should develop a strategic vision of how their state should move forward with HIT, says Mr. Rodgers, and what role Medicaid should play.

"In our state, we developed a road map. We brought all the stakeholders to the table and developed a consensus around, 'How are we going to move forward with statewide adoption of electronic health information exchange?' That gave AHCCCS the ability to start planning how we could contribute to this effort," he says.

Identify "exactly what you want to

accomplish," Mr. Rodgers suggests. "You don't acquire technology for the sake of technology. You invest in HIT to improve cost-effective results."

For example, if you deploy electronic prescribing to reduce your medication costs, you have to make sure your e-prescribing system is configured to achieve the maximum ROI.

Arizona's Medicaid program set out to reduce the number of duplicate laboratory tests. These usually occurred as a result of patients showing up in physician's offices without their lab results, which often meant another lab test was ordered.

Another goal was to reduce medication costs due to duplicate prescriptions written by different doctors for the same patient, which can cause adverse drug reactions and, in severe cases, emergency department visits. The third area being evaluated is reduction of inpatient costs due to unnecessary hospital admissions that occur because the patient's ED physician doesn't have access to full information.

"Before you set out to plan and develop a health information system, determine the health care outcomes that will justify your financial investment. Then, develop your information system specifications and project plan to optimize your outcomes," advises Mr. Rodgers.

Contact Mr. Rodgers at (602) 417-4111 or Tony.Rodgers@azahcccs.gov. ■

Soaring behavioral health costs growing problem for Medicaid

Medicaid now pays for 26% of total mental health expenditures, and rising costs of these services is a big concern for state Medicaid directors, according to a recent 50-state Medicaid budget survey from the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn*.

A total of 44 states indicated "moderate" or "significant" concerns with the growing cost of behavioral health care, behavioral health drug utilization, mental health-related emergency department use and inpatient hospital admissions for mental health services. One state indicated that of the top five prescription drugs paid for by Medicaid, four were for mental health.

"The largest drug category we spend on is atypical antipsychotic medications, closely followed by anticonvulsants and antidepressants, all of which are used for the treatment of mental health conditions both in adults and children," says **Charles Duarte**, administrator for Nevada's Division of Health Care Financing and Policy.

To address this, new criteria were put in for utilization management for psychotropic medications, particularly their off-label use in children.

In Nevada, state Medicaid is seeing a rapid increase in utilization of mental health rehabilitation services, as opposed to use of medication management and psychotherapy and other more direct therapy services. "Unfortunately, when you open the door a little bit, there tends to be problems when folks have access to that service," says Mr. Duarte. "It's not the biggest issue we are dealing with. Excessive utilization is a concern, but I think we have good strategies in place to manage that."

Changes were made to increase appropriate utilization of mental health services, to improve outcomes and quality, and reduce use of higher-level services such as inpatient psychiatric care.

The program set out to "reduce spending at the high end for hospital-based services by expanding community-based care," says Mr. Duarte, but has not seen an overall reduction in hospital or residential services. Instead, there was a very rapid increase in payments for rehabilitation services, almost 1,000% in some cases, since January 2006.

"We are going to put some utilization limits on use of those rehab services," says Mr. Duarte. "Most of this utilization has been occurring with children, so we have started doing aggressive care coordination for children with serious emotional disturbances," he says. "We are targeting kids with frequent admissions and readmissions to psychiatric residential treatment centers and psychiatric hospitals."

This initiative started in July 2009. "We are starting to see the fruit of that, but it's been a slow going process," says Mr. Duarte. "We are having success child by child, in getting them out of institutions and into community settings. But we don't have anything statistically that we can point to yet."

Mr. Duarte does expect that significant cost savings will occur as a result of the care coordination program, however. "That is my expectation—to see not only cost savings but improved quality of life for the child, because they are no longer a long-term resident of these facilities," he says.

Good news for patients

According to Mr. Duarte, "there is actually good news buried in all of this, particularly from the standpoint of children." He argues that cost-containment strategies such as care coordination and pharmacy policies

ultimately result in improved quality of care for patients.

"So, we think we are heading on the right track to get a better bang for our buck with behavioral health, but also make sure the patient gets better care," says Mr. Duarte. "That's assuming we don't have to cut all of this stuff as a result of our budget reductions."

Currently, limits are not being proposed on mental health services in direct response to the state's revenue problem. "We have proposed changing the state law to allow us to more cost effectively manage these classes of antipsychotic meds and anticonvulsant meds. We are currently precluded under state law from managing that by using a preferred drug list, but we will hopefully change that," says Mr. Duarte. "But if things continue to worsen as they have been, we may be looking at making much, much larger cuts in our services, not just with mental health, but in every group and almost every category of medical service."

Virginia's Children's Mental Health Program began in October 2007. It is a five-year demonstration waiver intended to reduce the length of stay for children residing in psychiatric residential treatment facilities (PRTF).

The intent of the waiver is to bring children under age 21 out of the PRTF. That reduces the institutional costs and allows children to be in the community with either their biological or foster family. "This is not only cost-effective, but is a cost savings for the Commonwealth," says **Cheryl Roberts**, deputy director of the Department of Medical Assistance Services (DMAS). "The average cost in a PRTF is almost double that of those in the community, both actual and projected."

Margarita Alegría, PhD, director of the Center for Multicultural Mental Health Research in Somerville, MA, says she expects that state budget cuts "will devastate behavioral health services. Budget cuts downsize behavioral health units, reduce the scope of hospital contracts, eliminate staff positions or freeze new positions, decrease administrative spending, make eligibility criteria more stringent for users and freeze or lower the payments of providers serving Medicaid population."

State Medicaid directors, she says, "are having to do more with less, since the demand for behavioral health is escalating, but the sources of funding are shrinking."

"Payers have to make tough choices, with negative tradeoffs, such as whether to reduce the pool of eligible patients for behavioral health care, reduce the payment to providers, or both," says Dr. Alegría. "Reduction in provider payments ultimately affect Medicaid eligibility, through worse access for a population that already may have poor access to many services."

The area of prescription drugs is being watched more closely, with more restrictions to use generic medications and greater accountability to curtail expenditures for inpatient hospital services, and emphasis on fewer days of hospitalization unless well justified, she notes.

"Most ancillary services, like transportation, peer counselors, and others, might also be curtailed," says Dr. Alegría. "Whether this reduction of behavioral health services causes a spillover to greater use of emergency health care services, homeless services, and increased criminal and juvenile justice services remains to be seen."

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How is nonpayment for 'never events' affecting Medicaid?

Medicare no longer pays for a list of "never events"—serious medical mistakes in hospitals that occur at hospitals, such as wrong-site surgery and serious medication errors—for discharges occurring on or after Oct. 1, 2008.

State Medicaid payment policies are following suit. In a July 2008 letter to state Medicaid directors, the Centers for Medicaid & Medicare Services (CMS) provided guidance to states related to coordination of state Medicaid payment policies with those adopted by the Medicare program, to prevent payment liability as a secondary payer. According to the letter, nearly 20 states already have, or are considering, methods to eliminate payment for never events.

"States have traditionally been the innovators that Medicare has built off of, such as the Medicaid medical homes model," says **Patricia MacTaggart**, lead research scientist and associate professorial lecturer in the Department of Health Policy at George Washington University in Washington, DC.

However, the reverse is also true. When Medicare pilots an approach to payment or service delivery, states often leverage the Medicare pilots. "States are positioned to say to their providers, 'Why not?' for Medicaid rather than 'Why?' once the provider is already engaged in the initiative with Medicare," she says.

Ms. MacTaggart notes that Pennsylvania Medicaid has a preventable serious adverse events initiative as one component of that state's efforts to promote quality health care, building off the broader

national focus on preventing medical errors. "This is one of the first states to link nonpayment to preventable serious adverse events," she points out.

Minnesota's experience

In Minnesota, state law requires all hospitals and same-day surgery facilities to report never events, and the Minnesota Department of Health is responsible for producing reports of these. Two years ago, Governor Tim Pawlenty announced an agreement among all hospitals in Minnesota that they would not bill any payer, including Medicaid, for a never event.

"Since that agreement, we have not identified any reduction in billing, because it was considered common practice among providers not to bill," says **Vicki Kunerth**, director of measurement and quality improvement for the Minnesota Department of Human Services.

"Minnesota has been proactive with our adverse events reporting system, which gets the credit for improving safety for all patients in all hospitals in Minnesota," she reports. "Because results are reported only by hospital, not by payer, we cannot determine a specific effect for Medicaid."

Colorado is in the process of establishing a Medicaid list of serious reportable events. According to **Jenny Nate**, MSW, a health policy analyst with the state's Department of Health Care Policy and Financing, the policy on Medicaid nonpayment to hospitals for serious reportable events has been completed.

"An executive order has been drafted and is awaiting the governor's signature," she says. "The purpose of this policy is not to reduce costs in our Medicaid program. We realize the savings will be nominal, due to the low incidence rate of never events among our Medicaid providers."

The policy was established, says Ms. Nate, to increase awareness of the need for improved quality of care in Colorado, and also to set an example for other payers in the state to develop their own nonpayment policies.

New York's goals

New York has a goal to not pay for avoidable complications and errors, using the CMS and National Quality Forum lists as the starting points. As of October 2008, the New York State Medicaid program has stopped reimbursement for three never events, with implementation of 11 other events to follow in early 2009.

Hospitals receiving payment under New York Medicaid will be required to provide information on each admission designating which complications were present on admission, and which ones occurred during or as a result of hospital care.

"This information will help the Medicaid program determine when increased payment for complications will be denied," says **Deborah Bachrach**, Medicaid director and deputy commissioner in the Office of Health Insurance Programs. "Our initiative with respect to never events and preventable complications is one part of an overall goal of paying for value in Medicaid."

That goal is represented in many payment reforms, she says, including paying more for high-quality primary care, reimbursing for services based on the complexity of the patient's illness and the services provided, and selective contracting for services such as bariatric surgery and specialty pharmacy.

"Our specific goals, with respect to inpatient payments, is to pay for service and medical care that has value, improves outcomes, and is medically necessary," says Ms. Bachrach. "Through our payment policy on never events, we will no longer pay for services that result in avoidable harm or care that does not benefit our members."

The hope, she says, is that the policy will provide additional incentives for hospitals to improve care, enhance patient safety, and prevent many avoidable hospital-acquired complications that harm patients and are costly. "We expect to see increased attention and focus in this important area of health care," she says.

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Will federal relief come? States need help now

It's not yet known exactly what federal help will be forthcoming to struggling state Medicaid programs, but one thing is clear: Many states are in survival mode and planning for the worst-case scenario.

"The reality is, there are people on Medicaid using services every day, and bills are coming in. States don't have the luxury of waiting and seeing what is going to happen," says **Robert W. Seifert**, senior associate at the Center for Health Law and Economics at University of Massachusetts Medical School in Charlestown. "And the later it gets in the fiscal year, the more dangerous it gets for states. You are watching your spending as the year goes on, and you know that by the end of year, you need a balanced budget."

For that reason, states are hoping for an indication early on that there will be some federal help in an economic stimulus package. "It won't happen before the federal administration changes and the new Congress convenes. But if there were some indication it was going to be retroactive, all the better," says Mr. Seifert. "Then states could breathe a little bit of a sigh of relief. But it's a tight year, however you look at it."

Nevada has gone through four cycles of budget reduction and, thus far, has only had to cut services and provider payments for its Medicaid program in the third round of cuts, which were implemented in September 2008.

Those cuts included reduction of hospital payments by 5% in aggregate, psychiatric payments, payments for certain pediatric specialty care services and obstetrical care services, services to people with long-term care needs who live at home, reduced available hours for personal assistance with activities of daily living, some significant reductions in the State Children's Health Insurance Program, capping dental coverage at $600 per year, and eliminating orthodontia and vision coverage.

"Those are the big things we have had to do," says **Charles Duarte**, administrator for Nevada's Division of Health Care Financing and Policy. "Luckily, with the other budget reduction rounds we went through, there were either reserve funds or other pools of existing funding out there that we were able to tap, to avoid more drastic reductions in services or payments."

In the state's proposed budget for fiscal year 2010/2011, additional reductions are outlined that have not yet been accepted by the governor. "But the projections in declining state revenue have worsened significantly since that document was produced in September 2008," he points out.

Mr. Duarte says the current downturn is "dramatically worse than the previous downturn," and that he is eagerly awaiting word of possible federal assistance. "We are certainly anxious to get some federal help," he says. "It won't help with our whole problem, but it could provide us in excess of [$50 million] and we'd be grateful if that were to happen."

If the worst-case revenue scenarios do materialize and there isn't any new revenue produced, such as with taxes, Mr. Duarte says there would need to be very dramatic cuts "across the board" to services for children and families, as well as the elderly and the disabled. "That would include reductions in optional services, elimination of programs altogether, and cuts in eligibility for optional groups," he says.

These are times when states are certainly not going to be adding anything new to any great degree, says Mr. Seifert. "I'd be very surprised if states were not just trying to stay where they are in terms of eligibility and benefits. That's probably the best that anybody could hope for." ■

Survey: Employers say cost is key barrier to coverage

Most employers that don't offer health coverage would not be willing to spend more than $50 per employee to offer a health plan to their workers, according to a new survey by benefits consultant Mercer. *(Editor's note: The survey can be accessed at http://www.mercer.com/referencecontent.htm?idContent=1325605.)*

The survey was completed by 545 employers that do not offer employee health coverage and nearly 2,900 employers that do.

When asked their primary reason for not offering health coverage, 43% said they can't afford it. Other reasons included employees being covered under other plans (20%), high work force turnover (9%) and the perception that employees would rather have more pay than health coverage (9%).

Asked how much they would be willing to contribute to offer a health plan, 59% cited $50 or less, the association says. Only 10% said they would pay at least $200. To put those results in context, Massachusetts' "play-or-pay" law requires employers who don't meet the "play" standard to pay $295 per employee per year to the state, and indications are that this amount might soon be adjusted upward, according to Mercer.

Half of all employers oppose

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play-or-pay laws, which would require employers to offer health coverage or pay into a government fund to cover the uninsured. Just 31% are supportive, and 19% neither approve nor disapprove. Wholesalers/retailers (68%) and manufacturers (56%) are most likely to disapprove of a play-or-pay requirement.

According to Mercer, almost all employers that do not sponsor health coverage have fewer than 500 workers.

"This finding highlights how tough it's going to be to ask very small employers to voluntarily take on the expense of providing health coverage," said Mercer partner **Linda Havlin**. "It also helps explain why even relatively low-cost catastrophic plans like HSAs have not made great inroads with small employers that find it financially challenging to offer coverage."

Just over half (53%) of employers support requiring individuals to have health coverage if they can afford it, either through their employer or purchased on their own. Nearly half of employers (46%) support having the federal government provide stop-loss protection to cover an employer's catastrophic expenses.

The survey identified employers with workers in Massachusetts, San Francisco, and Vermont, which have enacted broad-based health care reforms requiring employer compliance. The survey asked them what actions they had to take to comply and how burdensome those actions were.

Of the 384 employers with workers in Massachusetts, where reforms are the most complex, 79% have been required to take some action:

- collecting information to meet new reporting requirements (72%);
- establishing a new Section 125 (cafeteria) plan (41%);
- modifying an existing plan (12%);
- establishing a new plan to comply with the Employee Retirement Income Security Act (ERISA) (10%).

Interestingly, only 4% reported that those efforts required "considerable" resources. Most reported that they required "minimal or no resources" (58%), or "some resources, but [not enough to affect] other priorities" (38%).

Most employers are concerned about the potential impact of state or local health reform initiatives. Almost nine out of 10 large employers (86%) said they were concerned or very concerned about the impact on cost. In comparison, 71% are concerned about losing the flexibility to design programs to meet organizational needs, and 64% are concerned about losing ERISA protections.

About half of these employers say it is very unlikely that they will offer a plan in the next three years (49%), and only about one-fourth say it is even somewhat likely. ■

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