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In This Issue

Could this be Medicaid's 'great moment of opportunity?' Experts say it is

Even in the face of plummeting revenues, surging enrollment, and budget shortfalls, "it's a great moment of opportunity for Medicaid programs in many ways," according to **Stan Rosenstein**, principal advisor of Health Management Associates in Sacramento, CA. Rosenstein is former director of California's Medicaid program.

This is because there is a chance to shift the focus of the program from being just about fiscal issues, to "really define the role of Medicaid in the health delivery environment and how states and the federal government can improve the program, improve access and quality of care, and make Medicaid be an important component of broad health care reform," says Mr. Rosenstein. "We are really at a great moment where the federal government and the states can form a new partnership on Medicaid that is well overdue."

Stimulus is 'savior'

Mr. Rosenstein calls the American Recovery and Reinvestment Act of 2009 (ARRA) a "savior for the Medicaid program." "I cannot stress the importance of that action for saving the Medicaid program and

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Indiana's Medicaid waiver program covers more than 40,000 uninsured

More than 40,000 Hoosiers are now receiving health care coverage through the Healthy Indiana Plan (HIP), which began enrolling beneficiaries in January 2008. The plan is the first that allows a state to provide a benefits package to a low-income population that wouldn't otherwise qualify for Medicaid, modeled after a high-deductible plan and health savings account and using Medicaid funds.

Fiscal Fitness: How States Cope

In December 2007, the Indiana Family and Social Services Administration obtained a federal waiver that provided federal funding for 34,000 childless adults. Since that limit has been reached, any person in that category who applies for HIP coverage will be issued a denial letter and included on the wait list based on the date and time his or her application was received. Enrollment remains available, however, for parents and other caretaker relatives living with dependent children.

HIP is for uninsured Hoosier adults between the ages of 19 and 64 who earn less than 200% of the

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Opportunity

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really by it, saving the health care industry, since Medicaid comprises some 15% of all health care expenditures. It avoided cuts in every state," says Mr. Rosenstein.

Due to the budget shortfalls, states were going to be unable to continue to take care of their residents, he says. "Medicaid has been the backbone of the safety net, and the steps the president and Congress have taken have really saved the Medicaid program."

That said, though, whether states can avoid cutting benefits, or possibly even expand coverage, remains to be seen. "There is a wide variety of statuses for the states, and the ability to do more is going to vary," says Mr. Rosenstein. "Some states are not as affected by the economic downturn as others." For some states, such as California, the federal help will not be enough, and they'll continue to have problems just maintaining the Medicaid program as it is.

At a minimum, though, the economic stimulus means that states will preserve eligibility for their growing caseloads. States are required to preserve eligibility in order to receive increased Federal Medical Assistance Program (FMAP) dollars.

"Caseloads are still growing, because unemployment continues to grow. The stimulus package is going to maintain the safety net, which will expand out of necessity," says Mr. Rosenstein. "If someone has lost their job and children are uninsured, there is a safety net for them that is available because of the economic stimulus package."

For every 1% increase in the unemployment rate, 1 million additional individuals become eligible for Medicaid, but it also is notable that there are 1.1 million people who have become uninsured and don't qualify for Medicaid, he notes.

For some states, the stimulus means they'll be able to retain the comprehensive services they previously had, despite dramatic increases in enrollment. "Considering the state of so many of the budgets beforehand, I think that this would be a very good outcome for states," says **Neva Kaye**, senior program director for the National Academy for State Health Policy in Washington, DC.

Some damage being undone

Policy experts agree that the Obama administration's actions thus far have vastly improved the situation of state Medicaid directors.

"There are great things that the Obama administration has done, which are just vital to the people in the U.S. affected by the Medicaid program," says Mr. Rosenstein. "And we all are, whether we know it or not, affected by Medicaid."

First, the Aug. 17, 2007, directive from the Centers for Medicare & Medicaid Services (CMS) was overturned by Congress. "This was great news for state Medicaid programs," he says.

Through the "Dear State Health Official" letter dated Feb. 4, 2009, clear, consistent guidance was provided to states on issues important to Medicaid and State Children's Health Insurance Program (SCHIP) enrollees, states, and providers.

The letter notified all states that President Obama had issued a Presidential Memorandum directing the Secretary of Health and Human Services to withdraw the Aug. 17, 2007, and May 7, 2008, letters issued to state health officials and indicated that CMS would no longer apply the policies in those letters when reviewing SCHIP plan amendments or Section 1115 demonstration waivers.

"This is but one example," says **Patricia MacTaggart**, lead research scientist and lecturer at the Health Policy Department at the George Washington University in Washington, DC. Ms. MacTaggart formerly was group director for CMS' Center for Medicaid and State Operations and director of Minnesota's Medicaid program. "President Obama has met with the National Governors Association to begin a dialogue related to current Medicaid issues, ongoing Medicaid funding, and evolving health information technology opportunities."

This is a dramatic change from the policies of the Bush administration, when "consistency and transparency were not evident" for state Medicaid programs, according to Ms. MacTaggart.

Instead, she says, the relationship between the federal government and states became one of audits, reinterpretation of previous policy and restrictive, far-reaching regulations in significant areas of policy for states. These included targeted case management, provider taxes, school-based administration and transportation, outpatient hospital facility services, cost limits for certain providers, graduate medical education, and rehabilitative services.

"The Obama administration has illustrated, in a very direct and immediate way, a commitment to engage states in a real federal-state partnership for Medicaid and SCHIP," says Ms. MacTaggart.

Mark Trail, principal of Health Management Associates in Atlanta, says "several things right out of the gate have improved states' circumstance."

First, the economic stimulus package increased the FMAP to the federal portion of Medicaid's benefit cost for all states. "[The percentage for] states with higher unemployment increased even more," he says. "Without doubt, that step alone prevented states from having to make very substantial cuts to their programs."

As every state except Vermont has to balance its budgets each year, a state's ability to accommodate the increased enrollment and cost resulting from increasing unemployment is critical.

"It is not insignificant to recognize that the increased demand is occurring at a time when state revenues are decreasing. It's the perfect storm for a state," says Mr. Trail.

However, it also is important to note that the increased FMAP alone will not solve all of most states' budget shortages. "States will likely continue to seek other cost-reduction measures," he points out.

The ARRA stipulated that those cost-reducing measures could not include restricting eligibility beyond standards in place on July 1, 2008. Therefore, states needing additional saving will likely turn to utilization controls and benefits.

Trail adds that the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), reauthorizing the SCHIP program, also will help most states.

"Some states have expanded their Medicaid program to create their SCHIP. They are clearly helped," says Mr. Trail. However, most states will benefit even if they have a separate SCHIP, because the CHIPRA improved the funding formula and provided additional funds. This should relieve some overall budget pressure, thereby helping Medicaid programs.

Mr. Trail says three big challenges for state Medicaid programs going forward are the length of the recession, depressed state revenues, and further erosion of existing federal participation.

The latter, he says, is of particular concern for states affected by the six CMS rules that have only been postponed until June 30, 2009. These rules, if finally implemented, will substantially reduce federal participation in many states.

"Should they go into effect, states stand to lose hundreds of millions right in the middle of the current recession," says Mr. Trail. "States will be forced to implement much deeper cuts than even currently planned."

Six regulations need withdrawal

The six regulation packages still are in a status of needing to be withdrawn entirely. "Congress extended the moratorium on some of them through the end of June 2009, with the understanding that the Obama administration will withdraw those regulations," says Mr. Rosenstein. "That is vital, because that will take away billions of dollars of funding to vital health care services. So, those regulations need to be taken away, too. That's another important reversal."

Above all, there is a strong need to revitalize the relationship between the states and CMS. "Medicaid is a partnership between the state and federal governments. Somewhere along the line, the partnership was lost," says Mr. Rosenstein. "That needs to be re-established, so that people can work together on access to care, quality of care, and making sure that people get the services they need."

The problem was that CMS became primarily focused on cutting costs of the Medicaid program, so that states were treated as users of the program instead of partners, he says.

"The relationship got very difficult at the time, because of the direction the federal government had taken," says Mr. Rosenstein. "All states are willing to be accountable

for how they spend money. In fact, states are accountable every day; but there is a strong desire for people to focus on what the program was established for, which is to provide quality health care to the poor." There needs to be a balance between that goal and fiscal responsibility, he adds.

Future role of Medicaid?

Mr. Rosenstein says he would hope people will view Medicaid as a safety net for all Americans, not just the poor. "You never know when you will lose a job and not have income," he says. "Medicaid is also support for the safety net. The hospitals, for example, that Medicaid supports, those are the hospitals that operate trauma centers and burn centers. If any of us were in a car wreck and taken to a trauma center, that is a center that is highly dependent on the Medicaid program. So, *all* of us need that safety net, not just the poor."

Another example is nursing home care, which Medicaid doesn't cover to any degree. "Medicaid is the safety net for people who have to go into a nursing home or need in-home care," says Mr. Rosenstein. "It either doesn't cover things like personal care, or it does with very limited benefits. So, sooner or later, many of us are going to need it, if not for ourselves, for a loved one."

One school of thought is that Medicaid could expand its role to cover childless adults, who currently are not covered by the program regardless of how low their income is. A number of health care reform proposals say Medicaid should be a vehicle to cover the poor whether they have children or not.

"Medicaid would logically be the place to cover all of the poor at a certain level. They would have equal access to Medicaid, and any income above that would go into some other government-subsidized program," says Mr. Rosenstein. "This recognizes Medicaid for what it's really good at, which is coverage for low-income individuals. It does a really good job there."

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Fiscal Fitness

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federal poverty level (FPL), about $20,800 for an individual; do not have access to employer-sponsored health insurance coverage; and have been uninsured for at least six months.

HIP includes a Personal Wellness Responsibility (POWER) Account valued at $1,100 per adult to pay for initial medical costs; a basic commercial benefits package once annual medical costs exceed $1,100; and coverage for preventive services up to $500 a year at no cost to participants. Contributions to the POWER Account are made by the state and each participant, based on the ability to pay. No participant pays more than 5% of his or her gross family income. Also, no copays are required except for emergency department use. However, those copays will be returned if the service is deemed a true emergency, using the "prudent layperson" standard.

If all age- and gender-appropriate preventive services are completed, all remaining POWER Account funds, both state and individual, will roll over to offset the following year's contribution. If preventive services are not completed, only the individual's prorated contribution to the account will roll over.

Services covered by HIP include physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning and case and disease management. Mental health coverage also is included and is similar to coverage for physical health, including substance abuse treatment, inpatient, outpatient, and prescription drugs.

State faced a daunting challenge

From the approval of the Indiana Check-Up Plan by Indiana legislators in April 2007 to the start of the HIP program in January 2008, the state was faced with a condensed time frame for implementation. The following activities had to be completed in that short time frame: A waiver approval from the Centers for Medicare & Medicaid Services, development of a request for proposal, procurement process, contract negotiations with health plans, written program policies, rule promulgation, state plan amendment updates, readiness review criteria set and monitored, operations testing and marketing initiatives.

"All of these activities took place concurrently, with limited resources," says interim Medicaid Director **Pat Casanova**.

Currently, HIP is funded with cigarette tax revenue. For the current fiscal year, the cost of the program is estimated to be over $130 million. Unused cigarette tax revenues are reserved to fund the program in later years, when cigarette funding alone will not be able to fund the program. Previously, $47.5 million in cigarette tax revenue was needed to support the program, but

the state's Medicaid program will now receive $9 million from the economic stimulus package. "The increased FMAP will lessen the amount of the cigarette tax revenue that is needed to support the program," Ms. Casanova says. "The stimulus package significantly reduces the state's obligation, and, therefore, moves the break-even point between cigarette tax revenue and expenses further into the future."

Based on current state estimates, HIP could potentially expand coverage to 120,000 previously insured adults.

The state plans to offset the costs of coverage expansion by using a portion of their Disproportionate Share Hospital Funds and achieving savings in its existing Medicaid coverage. Beyond the savings needed for budget neutrality, the state also has agreed to achieve additional savings of $15 million over the five-year waiver period.

"The stimulus package will fund in the short term the increased enrollment of individuals needing Medicaid services due to the employment issues we are facing," says Ms. Casanova.

However, since the stimulus package only is a nine-quarter program, Ms. Casanova says if the recovery takes longer and is slower than those in recent years, there is concern about the "cliff" of expenses for built-up service needs without the concurrent revenue from this funding source.

"Before the stimulus, Family and Social Services Administration had begun working on a couple of initiatives that would help fill the gap between revenues and service needs—a pharmaceutical carve-out and a short-term retention of up to 5% of provider billings," says Ms. Casanova.

Indiana's commitment to a balanced budget over the past four years has maintained eligibility criteria, says Ms. Casanova, and even supported reducing or eliminating wait lists for certain services.

"Because they lived ahead of their income, a number of states have had to announce more restrictive eligibility criteria, reduced provider reimbursement rates, restricted access to services, or other draconian measures to reduce their budget deficits," she says. No budget cuts have been necessary for the state's Medicaid program thus far, and the Medicaid program will not cut services "except as a last resort," adds Ms. Casanova.

Instead, Indiana's Medicaid program is forging ahead with improving health outcomes through a variety of initiatives. These include improved data aggregation and reporting, transparency of quality information for patients and consumers, improving early access to prenatal care for pregnant women, and moving to a paperless system for communications and billing.

"Many of the cost-saving initiatives in Medicaid have grown out of transforming models of care for individuals in need," says Ms. Casanova.

For instance, the closure of the last center for the developmentally disabled in Fort Wayne replaced the outmoded institutional care model with community-based opportunities for inclusion and care. It also reduced the total spending from more than $60 million a year to less than $24 million, a savings of 60% for the same population.

Similarly, the elimination of the wait list for the Aged and Disabled Waiver significantly reduced the demand for nursing facility placements. This saves significant dollars currently, and even more in future years as individuals are staying in the community longer.

In addition to the new populations reached by HIP, the CareSelect care management program was created to serve the population of the aged (excluding the dual-eligible members), blind, physically and mentally disabled, members who get room and board assistance, members on MEDWorks, children receiving adoptive services, and members receiving select nondisabled home and community-based services.

"Neither the HIP nor CareSelect programs was threatened by the revenue projections per se, and the stimulus package is not the reason for continuing to fund them in the budget for the state fiscal year 2010 and 2011 biennium," says Ms. Casanova.

Looking forward, she says a key area of focus for the state Medicaid program "is assuring that these programs are working as we envisioned them, and improving outcomes for Medicaid members." ■

Stimulus could jump-start plans for cost-saving initiatives

"It's pretty clear that even with the stimulus funding, states are going to need to manage their Medicaid programs well," says **Neva Kaye,** senior program director for the National Academy for State Health Policy in Washington, DC. "It's something that they have always needed to do, but it gets to be even more important in times like these."

This means that state Medicaid programs will have to continue to press forward with quality improvement initiatives. "I think what is happening right now is creating a lot of opportunity. Those who have been thinking long-term will be able to capitalize on this quite

effectively," she says.

For example, many states have done extensive planning on how they could use and support health information technology (HIT), organize primary care, or implement medical homes. This planning will enable them to use the stimulus dollars to jump-start those plans. "It presents a whole new field of opportunity for states to advance and move some of their thinking into reality," says Ms. Kaye.

Since so many states are facing budget shortfalls, a lot of the help in the stimulus package will go exactly to what it was intended for—helping states maintain their Medicaid programs during these tough times. "But I think that other parts of the bill will support Medicaid programs in being innovative and moving forward," she adds.

Reform is critical

One of the biggest challenges for state Medicaid directors right now is to improve the cost-effectiveness of their programs.

"In a time of significant financial constraints, health care reform is not only important; it is critical," says **Patricia MacTaggart**, lead research scientist and lecturer at the Health Policy Department at the George Washington University. "States have historically found innovative service delivery approaches to address access and quality within financial realities."

Now states have the chance to move from concepts to implementation of real change, for the betterment of publicly funded enrollees.

"Transforming health care and health care delivery is not easy, but it *is* feasible, if the federal and state governments can rebuild the trust that has been lost over the last few years and work together as real partners," says Ms. MacTaggart.

States, such as private purchasers, have only four options to consider when money gets tight, she says: eligibility (eliminating a population group), coverage (cutting out an actual service), payment (reducing or not increasing payments to providers), and service delivery (more effectively and efficiently purchasing and delivering the service).

"The option with the least negative impact—and the one with the greatest potential for a positive impact—is in changes to service delivery. This is dependent on a better system of care and better information," says Ms. MacTaggart.

The stimulus bill provides funding for HIT infrastructure. This could allow states to implement the information tools necessary to assure appropriate utilization of services.

Ms. MacTaggart predicts that states will look to e-prescribing, e-health information exchanges of information, decision support enhancements for rate setting and quality oversight, and mechanisms for their staff to use to do their work "right the first time."

State budgets, as they tighten, often require cutbacks on state staff, so using human resources more effectively through HIT becomes even more necessary.

"States are looking at more web-based provider management, member management, and contract management, in order to have a greater impact with less staff," says Ms. MacTaggart. "Waste will be an immediate focus through fraud and abuse activities, review of overutilization, and focused payment efforts, such as not paying for 'never events.'"

As for cost-saving initiatives, economic realities will "force states to work on these, no matter what," says Ms. Kaye. "Even with the federal money, there are still budget gaps in some states, and you have to figure out what to do about that. That always presses you to look at cost effectiveness and quality and efficiency and to make those investments."

Ms. Kaye adds that for the past year, she has been involved with states advancing initiatives on medical homes for Medicaid and SCHIP beneficiaries and has observed "absolutely no slowing down on that. As a matter of fact, there is continued strong interest in it, as a way of making the system work more efficiently."

States such as Iowa and Minnesota that are already "marching down that path" toward medical home initiatives will continue to do so, she predicts. "They will not only continue to define and develop what is a high-quality medical home, but will look at ways of changing their systems, support practices, and reimbursement. There is a lot of interest in what these states are doing," Ms. Kaye says.

States may freeze reimbursements

States may seek to freeze or cut reimbursement for providers, but this is a difficult prospect since Medicaid rates are already low. "Medicaid may be a $350 billion program, but on a per capita basis, given the number of people it covers, it's really a pretty cheap program. There's not a lot of fat in that system to cut," says **Michael S. Sparer**, PhD, JD, a professor of health policy at Columbia University's Mailman School of Public Health, and author of *Medicaid and the Limits of State Health Reform*.

"There's not much you can do with reimbursement, although states do have battles with providers over reimbursement, and those will continue to play out over the years," he explains.

Similarly, the "big-ticket" items in benefits packages aren't a money

saver for states. "Either they are mandated by the feds, or they are things like drugs that you can't realistically cut," says Dr. Sparer. "So, you end up with services like podiatry, mental health, and substance abuse. You don't really save much money when you cut things like that; they are politically difficult, and it also could end up costing you money. If you don't get a mentally ill person the help that they need, they could end up in the ER, costing you all kinds of other money."

Some states are trying to save money on medications, either through purchasing pools or drug lists, although their leverage to save money in that area was significantly lessened by the Medicaid Modernization Act, which shifted all the dual-eligibility drug costs out of Medicaid into Part D.

"So, cutting benefits is tough, cutting reimbursement is tough, cutting drug costs is tough, and cutting eligibility is tough," says Dr. Sparer.

Another area getting a lot of attention is care management of the complex client who is chronically ill.

"A very high percentage of the Medicaid dollar goes to folks with five or more chronic conditions, many of whom are dual-eligible, most of whom have traditionally been excluded from state Medicaid managed care initiatives," says Dr. Sparer. "This is the area, in theory, where they can have the biggest impact."

However, this also is tough to do, he notes, and though you expect to achieve better quality, you don't necessarily save money by managing the care provided to the chronically ill.

"There are those who say the ultimate key to cost containment is greater use of HIT, and there is now obviously federal money for HIT," says Dr. Sparer. "We really should have better HIT, but in the short run, it's going to cost a lot of money. The feds are going to help pay for it right now, but the states are going to have to put in some money to pay for it. It's also administratively tough to do, particularly if you're in a state with a lot of solo practitioners and office-based docs."

So, while HIT, as well as improving primary and preventive care for Medicaid clients, could save money in the long run, Dr. Sparer says he doesn't see it as a short-term money saver for the states.

"The one area I think states are really going to try to experiment [with] is with dual-eligibles," says Dr. Sparer. "That is a very expensive population. It's a very difficult and high-cost population, and it's a very hard-to-manage population."

It's important to note that for what Medicaid does, says Dr. Sparer, "it's a pretty low-cost program" and ultimately, he says, what the states really need is help from the federal government.

"States are saying, 'We think Medicaid is an appropriate vehicle to expand coverage to the uninsured, but we need additional federal funding, given our requirements to have a balanced budget and our limited ability to raise money," Dr. Sparer says. "If Medicaid is really going to be the safety net for the low-wage worker and the uninsured in the U.S., the states can't be put in a position of financing a large chunk of the cost of that. They are going to need more help from the federal government, I think."

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Will Medicaid become the path to universal coverage?

During the first term of the Bush administration, Medicaid costs were rising and states were battling to stay even, says **Michael S. Sparer**, PhD, JD, a professor of health policy at Columbia University's Mailman School of Public Health in New York City.

"But during the second half of the administration, you saw real battles," he adds.

Looking backward, Dr. Sparer notes that from the '60s to the mid-'80s, "Medicaid was a pretty lousy program for poor people, with low reimbursement, tremendous interstate variation, and minimal benefits. But in the late 1980s, Medicaid became what it is today: The most successful program for the uninsured in American history."

During the late '80s through the early '90s, Medicaid saw major expansion, including the State Children's Health Insurance Program in 1997, but things slowed down in the early 2000s. Beginning in 2005, a number of states began trying to expand their Medicaid programs again.

"For the first time in a long time, you had a real philosophical debate over the future of Medicaid," says Dr. Sparer. The Bush administration took the position that Medicaid had gone too far, was no longer just a program for poor people, and was increasingly covering low-wage workers and middle-class people.

"Bush really tried to cut back states' efforts to leverage federal dollars and expansions," he points out. "Then Obama comes in and very quickly made clear that he views Medicaid and SCHIP as an important part of the effort to help the uninsured. That is a 180-degree different perspective."

In addition to passing SCHIP authorization and helping states

with the countercyclical financing of Medicaid, there also was talk of expanding Medicaid to cover the unemployed. "That was pulled out of the stimulus package because of Republican opposition," says Dr. Sparer. "But I think you will continue to see Medicaid expansion of a variety of sorts. The Obama administration views Medicaid as a means-tested health insurance program and publicly funded safety net, not just for the poor, but for the lower-wage worker as well."

Two parallel pressures

Dr. Sparer says going forward, there are going to be "two parallel tracks that are going along simultaneously." On the one hand, there is pressure to use Medicaid as a vehicle for aiding the uninsured, particularly in a time of rising unemployment.

"Medicaid as a vehicle for expanding access is clearly on the agenda," he says. "At the same time, there's a tremendous budgetary impact that leads to great pressure to cut costs. There's not a governor in the country that doesn't complain about the cost burdens that Medicaid imposes on their budget, even with the $87 billion coming in, and probably hasn't said at some point to his Medicaid director, 'Figure out how to save me some money in Medicaid.'"

This means that Medicaid directors are under tremendous pressure to simultaneously expand access and cut costs—a difficult position to be in. "I think the biggest challenge going forward is, 'How do you simultaneously use Medicaid as a vehicle to expand access to the uninsured while at the same time, not breaking the state budget?'" says Dr. Sparer.

"Medicaid started out as a welfare program, but that changed many years ago," says **Neva Kaye**, senior program director for the National Academy for State Health Policy. "The public's perception has taken a while to catch up to that. But as its role grows greater, there is a possibility that might change the public perception."

Could rising unemployment, making millions of additional Americans eligible for Medicaid benefits for the first time, fundamentally change how the public views the program? Dr. Sparer says it's just possible that it might.

"Medicaid is no longer just a program for poor people. That is clear," he says. "The $64 billion question is, does that mean the stigma that has arguably been attached to Medicaid will begin to fade away? I think that's possible." ■

Will provider rates be cut? Quicker, simpler payment can soften the blow

The number of states facing budget shortfalls will continue to grow, which means states will make some tough choices, including possible provider rate cuts, predicts **Stan Rosenstein**, principal advisor of Health Management Associates in Sacramento, CA, and former director of California's Medicaid program.

"I don't think we've yet hit the bottom of the states that are in trouble. I think we will be seeing a lot of states that will be in worse shape as things deepen," he says. "Every time you see new data on increased unemployment and that rate continues to grow, that tells me that states are not yet at the bottom."

A March 2009 report from the California Legislative Analyst's Office says that state is now facing an additional $8 billion deficit over the next 16 months. According to the report, the state is not collecting enough tax revenue to support its nearly $100 billion general fund—and more than 40 states are in a similar situation.

"So, tax revenues, at least in California, are continuing to drop," says Mr. Rosenstein. "States may well be in situations that are extremely difficult. The number of states that the economic stimulus wasn't enough for, I fear, will be growing and growing."

Since states won't cut eligibility, because this was protected by Congress, this will leave states with this difficult choice: Do they cut optional benefits, such as dental, podiatry, and optometry services, or do they cut provider rates?

"I fear that some states will be forced to make cuts in their Medicaid program. And no state wants to do that," says Mr. Rosenstein. "But still, the fundamental problem states will face is they have to balance their budget. If they don't have enough funding, they can't cut eligibility. The other places that states save large amounts of money are benefits and rates."

However, cutting provider rates could affect access to care, which is "a significant problem," he adds.

According to **Jesse S. Anderson**, state plan coordinator for Oregon's Division of Medical Assistance Programs (DMAP), the state has a number of proposed reductions pending legislative approval, including benefits and provider rate reductions. "We normally give providers a cost-of-living adjustment increase to rates each January. However, this is one of the reduction items that directly impact the provider," he says.

Mr. Anderson says DMAP periodically goes through exercises to reduce or eliminate administrative burdens for its managed care organization plans, as the penetration rate is fairly high in Oregon.

States are exploring ways of maintaining access even in the event of provider rate cuts. "There are certainly ways to make rate cuts more palatable," says Mr. Rosenstein. "You can reduce the billing requirements to make participation simpler administratively, or you can speed up payment. Often, providers will be less dissatisfied with the rate reduction if they get paid quicker."

According to **Cindy Christensen**, operations manager of Alaska's Division of Health Care Services, the majority of health care providers practicing in Alaska are enrolled in the state Medicaid program. "Based on the increasing number of claims that we process, recipient helpline statistics, and the types of inquiries received at the division level, Alaska Medicaid clients are typically able to access primary care providers," she explains.

However, clients do experience some difficulty accessing dental services and certain therapies for children. "This difficulty is largely due to work force shortages," says Ms. Christensen. "Participating dentists have told us that low rates were one reason that Medicaid recipients could not access dental services."

To address this, the Department of Health and Social Services requested and received a special appropriation from the Alaska legislature to increase dental rates, effective July 2008, but has very limited data to determine if this has improved access due to the short time frame.

In addition, Ms. Christensen says Alaska Medicaid has looked at the length of time from submission to payment for dental claims. A clean claim can be processed within seven days of electronic receipt. "Alaska also does not require its dental providers to bill third-party payers prior to submission of a claim to Alaska Medicaid," she reports. "Alaska Medicaid uses a pay-and-chase contractor to capture third-party dental payments."

According to a study published online in the November 2008 issue of *Health Affairs,* even if provider rates are increased, delays in reimbursement discourage Medicaid participation by physicians. The researchers linked state-level data on average reimbursement times to the 2004-2005 Community Tracking Study Physician Survey and found that increased rates may be insufficient to increase physicians' participation, unless they also are accompanied by reductions in administrative burden.

Peter J. Cunningham, PhD, a senior fellow at the Center for Studying Health System Change in Washington, DC, one of the study's authors, says he was surprised by the findings to some degree. This is because states have been moving toward greater automation of their Medicaid claims processing, which should speed up payment.

"On the other hand, we know from surveys and anecdotal evidence that physicians still complain a lot about slow payment and other administrative burdens in Medicaid," he says. "The results in this study confirm that slow payment does affect physicians' decisions to accept Medicaid payments."

Dr. Cunningham says the bottom line is that automation by itself won't necessarily speed things up in a way that's satisfactory to physicians. There continue to be administrative barriers for timely review and processing of Medicaid claims.

"Increasing fees alone won't necessarily increase access to physicians for Medicaid enrollees, if payment is slow," he points out. "There needs to be some attention to reducing payment time and other administrative barriers."

Certainly, some states are committed to increasing access for their Medicaid enrollees. These states are attuned to the problems with Medicaid reimbursement, and they are expected to make efforts to both increase reimbursement levels and speed up payment.

"However, other states that are more concerned with the strain that Medicaid is putting on their state budgets aren't necessarily looking for ways to further increase spending," says Dr. Cunningham. "On the contrary, administrative barriers to fast payment may be more or less deliberate as a way to both reduce Medicaid billing fraud, as well as general cost containment."

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Substance abuse costs in Medicaid are staggering: What are states doing?

People with substance abuse disorders cost Medicaid hundreds of millions of dollars annually in medical care, according to new research that examined records of nearly 150,000 people in six states. The study, *The Impact of Substance Use Disorders on Medical Expenditures for Medicaid Beneficiaries with Behavioral Health Disorders*, published in the January 2009 issue of *Psychiatric Services*, suggests that early interventions for substance abuse not only improve outcomes, but also save substantial amounts of money.

Substance abuse probably costs Medicaid programs a lot more than they think, says study author **Robin E. Clark**, PhD, associate professor of family medicine and community health at the Center for Health

Policy and Research at the University of Massachusetts Medical School in Worchester, MA.

As patients with substance abuse disorders got older, the medical care costs increased at a far higher rate than behavioral health costs. This suggests that there are not a lot of substance abuse services that successfully target the older age group. Therefore, there could be substantial savings and health benefits by focusing on those populations, says Dr. Clark.

The study found that 29% of the Medicaid patients with behavioral health disorders were diagnosed with substance abuse disorders in the six states, ranging from a low of 16.1% in Arkansas to 37.1% in New Jersey and 39.6% in Washington. For people with substance abuse disorders, the six states alone paid $104 million more for medical care and $105.5 million more for behavioral health care than for those patients who did not have an alcohol or drug abuse diagnosis.

If those findings were extrapolated to the entire country, the extra costs for those with substance abuse disorders would easily run into the hundreds of millions of dollars.

The most surprising finding, says Dr. Clark, was the remarkable consistency across states. "Medicaid programs in the six states we studied had very different benefits, served different populations, and operated in a range of health care environments," he says. "Yet, substance use disorders were consistently associated with higher behavioral health and medical expenditures."

The study's findings suggest that addiction is a problem for primary care, as well as for specialty treatment. "Left untreated, substance abuse or dependence makes it more difficult to manage chronic physical illness," says Dr. Clark.

Some of Dr. Clark's previous research shows that many Medicaid beneficiaries with substance use disorders never receive treatment in outpatient settings. Programs such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) that are provided in hospitals or emergency departments are a promising way to identify and engage individuals with substance use disorders.

"This is definitely an option that Medicaid programs are considering," he says. "New procedure codes were recently created to facilitate payment for SBIRT activities. My informal information is that at least 14 states have implemented some form of SBIRT in their Medicaid programs."

However, some of the care management programs currently used in Medicaid programs across the country specifically exclude—or simply do not address—behavioral health disorders.

"Our data suggest that identification and treatment of behavioral health disorders need to be a part of any serious attempt to improve the quality and reduce the cost of care for chronic illness," says Dr. Clark.

Efforts to manage health care spending are clearly intensifying. "What is different is that the newer programs may be more focused on cost than previously," he says. "Recent publication of results from a 15-site study of care management for Medicare patients was disappointing on the cost-savings front."

The medical home model is a popular emerging alternative that focuses care management on the practice level, says Dr. Clark, "but how well medical homes deal with substance abuse and chronic illness remains to be seen."

Significant savings are possible

In Oregon, the use of SBIRT is being actively promoted. "This is something I very much would like to see implemented throughout the state of Oregon by the fully capitated health plans," says **Karen Wheeler**, addictions policy manager in Oregon's Department of Human Services. "And we have some efforts under way to promote that."

Currently, there is a department initiative to integrate additional mental health services into primary care. A primary behavioral health integration tool kit, including SBIRT, was sent out to the state's managed care plans, mental health organizations, fully capitated health plans that manage the primary health care's physical health and the addictions benefits, and the medical directors who work in those plans.

The state's health services commission approved the billing codes last year to allow providers to be reimbursed for SBIRT. "So, now it's a matter of the plans implementing the codes and allowing people to bill for that service," says Ms. Wheeler.

Ms. Wheeler says she hopes to see cost offsets similar to the state of Washington's, when SBIRT was implemented in some of its EDs.

Researchers from the University of Washington presenting at the October 2008 annual meeting of the American Public Health Association reported that when SBIRT was implemented in nine hospital EDs in Washington state, overall Medicaid costs for working-age disabled clients who received a brief intervention were $177 lower per member per month, compared to those who didn't receive an intervention. The lower costs resulted from a decrease in inpatient hospitalization costs associated with subsequent ED admissions.

"There is clear potential for savings in health care costs and other costs for social services and criminal justice," according to **Richard L. Brown**, MD, MPH, associate professor in the department of family medicine at the University of Wisconsin's School of Medicine and Public Health. Dr. Brown also is clinical director of the Wisconsin Initiative to Promote Healthy Lifestyles.

"I expect that other states will jump on board once they understand all that SBIRT has to offer," says Dr. Brown. "The potential for benefit here in Wisconsin is especially large." About a third of all patients in the Wisconsin Initiative to Promote Healthy Lifestyles screen positive for risky or problem drinking or drug use.

Ms. Wheeler says the last study on costs of substance abuse for Medicaid in Oregon was done in 1996, and it showed decreased costs after Medicaid clients obtained addiction treatment. "We have been citing that study for a long time, and it's pretty old; but while other states have done cost offset studies, we haven't had the resources," she says. "We do know that whenever you address addiction issues, wherever the person is, whatever system they are involved in, if you can help somebody receive treatment you see cost offsets."

The governor's recommended budget includes some significant cuts to general funds that support addiction services in Oregon, but also includes an expansion of the number of people covered under the Medicaid program. "The stimulus package will help us to avoid any cuts this current biennium," adds Ms. Wheeler.

For SBIRT to be implemented, however, training will be needed, including development of a web site to teach physicians how to implement the tool in their own practices.

As for funding, Ms. Wheeler says "we will have to leverage anything we can get. We do have a funded grant from Oregon Health & Science University to train physicians and residents, and develop a curriculum to implement SBIRT. That is something we have locally that I am pretty happy about."

Addictions and mental health are *"the* topics right now over at the capital," she reports. "People are hearing loud and clear that treating addiction and helping people get into recovery is a way to save money in the long run and help the economy. And the recovery voices are coming out louder than ever right now. People who have accessed services are coming out and speaking more than I've ever seen."

Budget cuts are obstacle

However, as many states face significant budget shortfalls, substance abuse intervention programs for Medicaid may be cut or curtailed.

Massachusetts also has plans for statewide reimbursement of SBIRT through Medicaid. Several additional new strategies for early-intervention substance use disorder treatment options are being developed and piloted. Some examples of these efforts include:

—The current service delivery model by the MassHealth Transition Age Youth workgroup is implementing the Children's Behavioral Health Initiative.

—The MassHealth Primary Care Clinician Plan and Massachusetts Behavioral Health Partnership are modifying the Addictions Recovery Management Service model to adapt for treating young people covered under the MassHealth plan.

—The current MassHealth initiative, teaming up with the Department of Public Health's Bureau of Substance Abuse Services and University of Massachusetts Medical School, is planning the widescale implementation of SBIRT in medical settings.

"The health benefits of engaging members in lifestyle changes and substance use disorder treatment during the earlier stages of substance abuse will lead to cost savings in each instance that a chronic addiction, a chemical dependency, or a traumatic injury is averted," says **Tom Dehner**, Massachusetts' Medicaid director, "Across the nation, the SBIRT pilot studies have demonstrated meaningful health outcomes and health care spending offsets."

However, the realities of the state's budget mean these programs have been put on hold. "Certainly, MassHealth programs have to refocus our attention and efforts to deal with new budget developments," says Mr. Dehner. "But these pilots and implementation activities remain on our work plan, even if they have been temporarily delayed."

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NCSL to conduct Health Disparities Project to help educate state lawmakers

The National Conference of State Legislatures (NCSL) in Denver announced in early March that it has launched the Health Disparities Project in an effort to not only identify possible disparities in health care for minorities in the United States, but also to inform policy-makers to reduce any disparities.

"The short-term goal of the project is to provide resources and databases for state legislators to assess how state policy—either in place or under consideration—will impact health care quality and access for racial and ethnic minorities," said **Melissa Hansen**, a health policy associate at NCSL.

The NCSL said in a news release that, for example, American Indian women are almost twice as likely to die from cervical cancer than white women. African-American men, it said, are diagnosed with heart disease less often, but are 30% more likely to die from it than white men.

"This does not take into account those who remain undiagnosed, due to disparities in access to preventive care," the NCSL said.

The best practices and policy options discovered through the Health Disparities Project are expected to provide state legislators with access to various state models that work to reduce health disparities.

NCSL said it will work with lawmakers to help them understand how specific policies either narrow or widen disparities in health care for racial and ethnic minorities.

The project is being conducted with support from the U.S. Department of Health and Human Services' Office of Minority Health. ■

NHPCO reports one-year stay secured on benefits cut

The National Hospice and Palliative Care Organization (NHPCO) reported that the nation's hospice community "claimed a significant victory" when President Obama signed The American Recovery and Reinvestment Act of 2009.

The law, according to NHPCO, includes a one-year moratorium on cuts in Medicare funding for the more than 4,700 hospice programs in the United States, a move that had been made by the Bush administration last year.

NHPCO said the phased funding cut would have taken $135 million away from hospices in FY 2009, threatening quality end-of-life care for patients and eliminating about 3,000 jobs. ■