State Health Watch
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In This Issue

Some Medicaid cuts appear to be "penny wise but pound foolish"

If a cutting an optional service saves Medicaid $5 million, will this cause costs to increase by $5 million in another area of the program? "That is the incredibly difficult thing with Medicaid in general," says **Stan Rosenstein**, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director. "It is very hard to do any cuts that don't have a ripple effect."

There is no question that Medicaid directors are currently making cuts that may end up costing the program more over the long term, according to Mr. Rosenstein. "I've been in this business 33 years, and I've never seen state budgets worse. Most states have been facing budget problems for five or six years now," he says.

The economy has yet to recover from a state tax revenue standpoint, Mr. Rosenstein adds. "It is certainly not at the level where it used to be," he says. "Any low-hanging fruit or easy cuts have been made."

That means that Medicaid directors are faced with making the kind of cuts that may end up costing the program more money later, which is "a tough situation," Mr. Rosenstein says. "Every time I've ever looked at it, we've always known that making

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Illinois Medicaid makes bold move with its managed care expansion

Major Medicaid reform legislation signed by Illinois Governor Pat Quinn in January 2011 is projected to save $624 million to $774 million over five years, reports **Theresa Eagleson**, administrator of the Division of Medical Programs for Illinois' Medicaid agency.

"The biggest portion of that savings comes from better coordination of care, and the lower payment rates in the end for institutional services, both hospitals and nursing homes," says Ms. Eagleson.

There is a wide range in the estimated savings because it's not yet known what form the care coordination will take, says Ms. Eagleson. "Illinois is a very diverse state. We don't think that the same form of care coordination is going to work in every area, so we can't put an exact number on it," she explains.

Fiscal Fitness: How States Cope

Currently, the $15 billion per year Medicaid program serves 2.8 million recipients, says Ms. Eagleson. Although 1.8 million are enrolled in Illinois Health Connect, a primary care case management program, only 200,000 are enrolled in comprehensive managed care plans.

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The Newsletter on State Health Care Reform

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Cover story

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some cuts could have a detrimental cost impact over the long term. But budgets have to be balanced on an annualized basis."

States at crisis point

The loss of the enhanced Federal Medical Assistance Percentages (FMAP) in June 2011, says Mr. Rosenstein, "is an enormous drain on state budgets and Medicaid programs. It's really become a crisis point for most state Medicaid programs."

Since states cannot reduce eligibility due to Maintenance of Effort requirements, says Mr. Rosenstein, they're forced to look for short-term savings by cutting the benefits people receive and the rates paid to providers.

"The Medicaid program must operate in the context of the overall state budget," Mr. Rosenstein explains. "The problem you face is that Medicaid is typically the second largest spending program in state budgets. As the Medicaid director, your program has to take its share of program cuts. You're in a situation where states don't have enough money."

Mark Trail, managing principal at Health Management Associates, says that for most state Medicaid programs, the number of options that exist to manage costs is getting smaller. Traditionally a state has had four areas to think about when considering how to manage cost of the program, he says.

"The four things that cost money in Medicaid include the people covered, the services included, the price paid for those services, and how much of those services are used," says Mr. Trail.

The American Recovery and Reinvestment Act and the Affordable Care Act took the "tool" of cost management via eligibility rules away from states, notes Mr. Trail. "Most states have already reduced the optional services they offer, so what might be left for most would not generate much savings," he adds.

Reducing provider rates has become increasingly difficult, given the requirements to maintain access as required in federal regulations, says Mr. Trail. Other approaches, he says, are managing utilization of services through managed care or requiring prior authorization for certain services. "Most states have employed many of these strategies, in one form or another," says Mr. Trail.

Costs are shifted

When eliminating optional services, says Mr. Trail, states assume the savings will be the amount previously spent in that service category. "They seldom consider how they may actually drive care to another service," he says.

In most states, adult dental care only covers emergency care, notes Mr. Trail. "Failure to control pain and/or infection will almost always end up in an emergency room," he says.

Judith Solomon, co-director of Health Policy at the Center on Budget and Policy Priorities (CBPP) in Washington, DC, says that some Medicaid cuts will cost more in the long run, "but because they save money in the short term, with an eye to closing a budget deficit, that's what states often do."

Since states are required to balance their budgets every year, it's hard to rely on forecasts of savings in future years, or even take into consideration that cuts will cost more money down the road, says Ms. Solomon.

The CBPP's fiscal team reviewed 31 budget proposals for Fiscal Year 2012 in its February 2011 report,

Governors are Proposing Further Deep Cuts in Services. Some of the cuts will cost more in the long term, according to the report, such as cutting nursing home diversion programs and adult optional benefits.

If a certain provider classification is eliminated, says Ms. Solomon, such as podiatry or adult vision, the patient is likely to see a physician instead because Medicaid is required to cover physician services. "If someone is seeing a podiatrist, they would probably have to go to an orthopedist, or if a vision problem is being dealt with by an optometrist, the patient would probably go to an ophthalmologist," says Ms. Solomon.

The fiscal impact of this kind of cost-shifting is difficult to measure, says Ms. Solomon. "I don't know that it's necessarily more expensive, but it's not a true savings. It's hard to know how that plays out," she says.

Ms. Solomon notes that Kansas is eliminating funding for 850 families of children with severe emotional disturbances. "These are kids who very easily can end up in residential treatment programs, if their family loses the means of treatment that allows them to handle children with significant needs in the home," says Ms. Solomon.

Regarding steep provider payment cuts, Ms. Solomon says that these could mean less access to certain providers and more utilization in other areas. "The problem is that it's really hard to quantify that," she says.

There is typically no analysis done to take into account this kind of cost-shifting when Medicaid cuts are planned, adds Ms. Solomon. "When the budget people who are doing the calculations say what the savings are, they don't count that," she says.

She points to the 10% additional provider rate cuts in Texas and South Dakota. "In states that already have pretty low provider rates, does it mean that people will end up not getting primary care and end up needing more expensive care? It's really hard to say with certainty," says Ms. Solomon.

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Fiscal Fitness

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Under the new law, at least 50% of Medicaid and Children's Health Insurance Program (CHIP) recipients will be enrolled in comprehensive managed care plans by Jan. 1, 2015, says Ms. Eagleson.

Cost savings are estimated over a 5-year period, says Ms. Eagleson, because "these result from better quality of care, and it takes time to achieve those savings."

Moving toward integrated care

An Integrated Care Pilot program is under way in Illinois' suburban Cook county and surrounding counties, for the elderly and disabled population. "That is our first move toward integrated care," says Ms. Eagleson. Two managed care companies were competitively procured, she says, and the agency is working on getting contracts signed.

"It's mandatory managed care, but with a lot different parameters on it than traditional managed care, at least in our state," says Ms. Eagleson. "There is a lot of money tied to performance outcomes."

These include clients getting certain medical tests done in a timely fashion, satisfaction with the type of services they are getting, their ability to function independently in the community, and follow-up visits occurring within a certain amount of time after a hospitalization.

"We are tracking all kinds of performance outcomes. We are actually tying dollars to the plans," says Ms. Eagleson. "They will be passing that on to the provider community, in order to incent different behaviors. That is the building block for the 50% goal in our legislation."

The legislation defines coordinated care as having many different components, notes Ms. Eagleson, including use of electronic health records and looking at the person holistically. "It has either a full-risk capitation option or a partial-risk option," she adds. "That is a big component of our Medicaid reform bill."

IT challenges

The law includes provisions for development of a new Medicaid Management Information System (MMIS) incorporating Medicaid Information Technology Architecture standards, and new eligibility, verification, and enrollment systems. These will be integrated with the MMIS and with health insurance benefits exchanges to be implemented in 2014, says Ms. Eagleson.

"If that is approved federally, we can get up to 90% match to that," says Ms. Eagleson. A comprehensive IT plan is being developed for how all the state's agencies, including the Medicaid program, will coordinate, adds Ms. Eagleson.

"We already have an RFP on the streets for a planning vendor for that," she says. "It is still in the development stage right now. We understand it's coming quick."

Short-term savings

The law also provides for residency verification, identification of third-party liabilities, and civil monetary penalties enforceable through lien authority to deter fraudulent applications, notes Ms. Eagleson.

Ms. Eagleson says that Maintenance of Effort requirements, under both the American Recovery and Reinvestment Act and the Affordable Care Act, were carefully considered. "We don't want to lose any federal match. We are not trying to change any eligibility thresholds," she says. "We are just trying to tighten up how we validate whether somebody is eligible for the program."

Residency will be verified, in order to eliminate the passive redetermination which occasionally occurs, she says. A recipient "lock-in" program will discourage drug-seeking behaviors by limiting clients to designated providers, in order to control program abuse, says Ms. Eagleson.

The legislation includes tightening of pharmacy utilization review, and separate legislation reduces the amount paid in prompt pay interest to pharmacy and nursing home providers, she reports.

"Those are some short-term savings that will help pay for the upfront costs, that we hope will create long-term savings," says Ms. Eagleson.

Care will be better integrated for Medicaid clients, says Ms. Eagleson, with better coordination across agencies. "We are breaking down barriers between provider types and state agencies. We are really reforming the way the system works," she says. "Better coordination leads to better outcomes, which leads to less cost."

New populations

Illinois has had a primary care case management system in place for some time, notes Ms. Eagleson. "We've had a voluntary plan for pretty much anyone, except those who are federally excluded from being in mandatory managed care. But we are not a state that has heavily used managed care companies with capitated plans," she says.

When a decision was made to take bold steps toward integrating care, says Ms. Eagleson, the population in the Integrated Care pilot was chosen, consisting of 40,000 seniors and disabled clients.

"We are one of the first states, I think, to do something that big," says Ms. Eagleson. "We are phasing it in by services." First, the more traditional services of hospital, pharmacy, physician, and mental health services will be provided, she explains, followed by long-term care services.

"We have been working really closely with all kinds of stakeholders on that," says Ms. Eagleson. "People want to make sure that the client's needs aren't lost in this. We are really trying to measure outcomes for the individuals we are serving."

While a small number of states have expanded Medicaid managed care, and many are considering doing so, says Ms. Eagleson, long-term care services haven't been included. "There are some states who started this before us, but not with the complex elderly and disabled population," she explains. "To get to 50%, we have to go further than that, too. We are not solely focusing on seniors and people with disabilities. That was just our first step."

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Now, tougher decisions are on table for states

When a program funded through state-only dollars is targeted for reduction or elimination, there is a possibility that it can be funded through Medicaid instead, notes **Patricia MacTaggart**, a lead research scientist and lecturer in the Health Policy Department at George Washington University in Washington, DC.

"This results in the need for less state dollars because of the federal match. But most of these type of 'fixes' have been made in previous years," says Ms. MacTaggart. "Now states, providers, and enrollees face tougher decisions."

The question is whether a program can present payment methodologies or service delivery innovations that will allow the care to be delivered more efficiently and effectively, says Ms. MacTaggart.

"There is always the limitation of time and knowledge, but most states do their homework regarding fiscal impact," says Ms. MacTaggart. "There are political and practical realities that result in changes being made before the full impact of the previous change can be fully analyzed."

There is always the possibility that a program can successfully lobby to prevent its elimination, says Ms. MacTaggart. "However, the program may be competing with other evidence-based, cost-saving programs in a time where the immediate funding is problematic for all of them," she notes. "Many excellent programs save money over time, but don't always do it in the initial fiscal year."

Programs should not be focused on in isolation, says Ms. MacTaggart. "States don't buy programs. They buy services that prevent and address health care issues," she says.

Viable programs must address how they fit into the evolving payment and service delivery models, says Ms. MacTaggart, and incorporate health information technology into their approaches to improve quality and administrative efficiencies.

In some cases, though, a pro-

gram can reduce immediate costs through reductions in admissions or readmissions to hospitals, emergency rooms, or nursing homes or has an impact on high-cost, high-risk publicly funded enrollees, notes Ms. MacTaggart.

In this case, says Ms. MacTaggart, "the cost consideration changes from the cost of doing to the cost of 'not doing.' In these tight fiscal times, there aren't easy or necessarily great options to choose from. "Hard decisions are reality."

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Illinois' Medicaid MC expansion is unique

It is the broad inclusion of all services that makes Illinois' managed care expansion unique, according to **James Parker**, deputy administrator for medical programs at the Illinois Department of Healthcare and Family Services.

"That is what I think other states will be going to," says Mr. Parker. "Instead of carving out behavioral health, or long-term community supports, we are putting all those services that people need in one contract."

To date, Illinois Medicaid hasn't had to cut any optional services, says **Theresa Eagleson**, administrator of the division of medical programs for Illinois' Medicaid agency. "Hopefully, this will avoid us spending the money on the more traditional institutional services down the road," she says. "Hopefully, we can avoid those cuts. State budget situations aren't looking great, but that is our hope."

Ms. Eagleson says that the managed care expansion is in no way an attempt to reduce services, but rather, to enable clients to access the care they need. "We often hear, especially with more complex mental health or substance abuse issues, that clients need to deal with not only a myriad of providers, but also different funding streams from the state," she says.

The managed care expansion will simplify things for both providers and clients, says Ms. Eagleson.

According to Mr. Parker, as many as 40% of Illinois Medicaid's high-cost, high-needs clients have a behavioral health diagnosis. For this reason, he says, it's very important to integrate behavioral and physical health care.

"There is a lot of evidence that people with behavioral health problems have much worse physical health care," says Mr. Parker. "This is because they are often only intersecting in the behavioral health system. If you can tie the two together, it is much more likely their needs will be met."

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Lost fiscal opportunities in store for Medicaid programs

While opportunities for cost savings exist in the Patient Protection and Affordable Care Act, some states will be unable to take advantage of these due to severe budget shortfalls, according to **Stan Rosenstein**, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director.

"There are a lot of terrific options, but some states may have difficulty coming up with the 10% match, as terrible as that sounds," he says. "If you are cutting programs drastically, it's pretty hard to come in and ask for any money for a new program. It is a very good match rate, but it is coming at a very difficult time."

Mr. Rosenstein says that the decreasing revenues and greater demand seen in states with high unemployment is a "classic problem" that Medicaid has faced for years. "At the times they have the most demand, there is the least state revenue," he says.

Even when unemployment starts decreasing, state budgets typically take about two years to recover from that point, adds Mr. Rosenstein. "We've got a ways to go in this crisis. The situation is compounded by the loss of the FMAP [Federal Medical Assistance Percentages]."

The loss of the FMAP funding, says Mr. Rosenstein, means that states will need approximately 30% more state revenue for their Medicaid programs. "That is a major hill to climb. That creates a crisis, I think, in almost every state," he says.

Some Medicaid directors are interested in implementing major delivery system or payment reforms, but aren't able to do so due to their current budget shortfalls, says **Judith Solomon**, co-director of Health Policy at the Center on Budget and Policy Priorities (CBPP) in Washington, DC. "Those broader reforms are harder to do. To the extent you can even forecast savings, they are not going to be, in most cases, in this budget year," she says.

Upfront costs too great

There are upfront costs involved in setting up a care coordination program which can eventually keep asthmatics or diabetics out of hospitals, notes Ms. Solomon. "The savings will be in the next two, three, or four years, with the need to balance the budget this year," she says. "That's why those things are often given

short shrift, which is unfortunate."

Another obstacle is that many Medicaid programs are currently operating short-staffed due to budget cuts, says Ms. Solomon. "You need people to carry out these policies and design them. That is difficult in states that have people out on furloughs," she says. "It's easy to cut a benefit. You just stop providing it. It's a little harder to design a program that will better manage care."

Budget is priority

Adult dental services is a commonly cut optional benefit, notes Mr. Rosenstein, but doing away with this benefit is likely to increase costs down the road. "This is an optional benefit that states don't have to provide," he says. "But there is no question that ignoring dental disease will have negative health effects over the years, leading to ER usage and other problems."

Longer-term savings can be achieved by fraud prevention and better management, notes Mr. Rosenstein. "States should be doing those things, but right now they are forced to balance the budget," he says.

Medicaid programs are increasingly putting caps on services, such as the number of covered prescriptions or hospital days, says Mr. Rosenstein. "Nobody wants to do that, but it may be all they can afford. They may think it's better to cover the most critical prescriptions rather than no prescriptions," he says. "When you don't have enough money, you are forced to prioritize."

If a state invests in a program that will result in considerable savings three years later, says Mr. Rosenstein, that doesn't help to balance this year's budget. States are left with two choices, he says.

"You can look at reducing benefits—and some states have already gone pretty low—or you can reduce your rates and perhaps have lower access," he says. "The tradeoff is, is it better to have less access to a service or not have the service at all?"

Mr. Rosenstein says that is the question that is now confronting most state Medicaid directors every day. "They may decide that having less access to prescription drugs is better than having no access at all by eliminating it," he says. "These are all terrible decisions that policy makers have to make." ■

Cost shifting is the issue with nursing home diversion

For decades, a California long-term care program provided case management for about 12,000 elderly Medicaid clients who qualify for placement in a nursing facility but want to remain in the community, but it is now faced with total elimination.

The local Multipurpose Senior Service Program (MSSP) has 41 sites statewide, all non-profit agencies who provide the case management staff, according to Governor Jerry Brown's budget proposal. Clients must be 65 years of age or older, currently eligible for Medi Cal, be appropriate for case management services, and certified or certifiable for placement in a nursing facility, according to the proposal.

The budget proposes to eliminate the MSSP program, which operates under a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver, says **Sarah Ludeman**, spokesperson for the California Department of Aging. This would result in savings of $19.9 million in general funds for 2011-2012, says Ms. Ludeman, and would also result in the state losing $19.9 million in federal funds.

In addition to case management services, says Ms. Ludeman, MSSP funds are used to provide adult day care, housing assistance, chore and personal care assistance, protective supervision, respite, transportation, meal services, social services, and communications services.

The MSSP program assists seniors in obtaining access to these services elsewhere in the community or through state programs first, and uses MSSP funds as a last resort for any potential gaps in needed care, according to the budget proposal.

Due to the state's fiscal condition, and the need to close a $25.4 billion budget gap, MSSP is one of many state programs being proposed for elimination, says Department of Finance spokesperson **H.D. Palmer**.

The estimate of $19.9 million in savings assumes that the policy is implemented June 1, 2011, after appropriately notifying the federal government, beneficiaries, and providers of the change, says Mr. Palmer. Both houses of the legislature have heard the issue, but at press time had not taken any action on the Governor's proposal, he reports.

All hands on deck

On the morning of January 10th, **Eileen M. Koons**, MSW, ACSW, director of Huntington Senior Care Network, and her staff heard that their program was up for elimination. "We statewide MSSP sites took an 'all hands on deck,' 'drop everything' approach."

The program had already had a 10% reduction in 2008, says Ms. Koons. "That was hard to weather, but we figured out to how to survive with that. We have been flat-funded for the 28 years of our existence," she says.

Ms. Koons says that she was worried about the program being targeted for a reduction, but was shocked to find it was slated to be cut altogether.

"This is a long-standing program

with a strong history of high-quality services and no issues of fraud, waste, or abuse," says Ms. Koons. "It's openly acknowledged to be a cost-saving alternative. As a nursing home diversion program, it's exactly the population that needs to be focused on."

Cost shift wasn't considered

During a briefing on the health and human service cuts, Ms. Koons and her colleagues asked agency staff why the program was targeted for elimination. "The response that we got then, and all the way through since then, is that they scored the savings of elimination and did not attempt to quantify the cost shift. It was as simple as that," she says.

Ginni Bella Navarre, the Legislative Analyst Office (LAO)'s senior fiscal and policy analyst, acknowledges that the impact of cost shifting wasn't considered. "The assumption was made that the entire cost of the program would be saved," she says.

Ms. Navarre says that the LAO's recommendation is that the infrastructure of the program should be maintained, with a $5 million reduction in funding. "Given the general fund condition, and the need to achieve savings, we recommend reducing General Fund support for MSSP by $5 million in 2011-12. If the legislature is considering reductions in other community-based programs throughout the state, we recommend that they consider maintaining the infrastructure of the MSSP program," she adds.

The LAO also recommended that the legislature encourage the Department of Aging to work with the federal government to reduce administrative costs associated with administration of the waiver, says Ms. Navarre.

"That way, if they are getting a $5 million reduction, maybe they can achieve some of that savings in operational costs," says Ms. Navarre. "That would limit the impact on the actual number of people they are able to provide services to."

Different from IHSS

A common misconception, says Ms. Koons, is that the work of MSSP is duplicative with the services provided by the state's In Home Supportive Services (IHSS). With MSSP, says Ms. Koons, the primary service is care coordination/case management, and ability to pay for some ancillary services not funded by other state Medicaid programs, after exhausting family and community resources.

Most MSSP clients also receive funding for personal services that may allow them to remain at home through IHSS, says Ms. Koons, but MSSP provides a completely different service. "A lot of our clients depend on IHSS to stay at home, so that's one of the resources we make sure is working OK," she says. "We are more of a wraparound service. We are driven by a care plan that looks at the big picture."

Ms. Koons says that this includes working with the patient and caregivers to address the client's health care and social service needs, home safety, managing medications in the home, ensuring regular access to medical care, and end-of-life issues. "It's much different from providing assistance with tasks that need to be done," she says. "We are replicating all the things that a nursing home would attend to, in the home setting."

While IHSS benefits are sufficient for the vast majority of participants, says Ms. Koons, the population served by MSSP needs much more. "IHSS is not enough for them," she says.

Ms. Koons directs a hospital-based MSSP site, so many of the referrals she receives are discharged patients who already have IHSS but need more support to be able to stay at home. "Some of these patients go to a nursing home for a short time, but then we can help them return home and enroll them," she explains.

All participants have multiple chronic conditions, many are taking 10 or 20 medications every day, and many have impairments in their physical abilities, says Ms. Koons. "These are all indicators that these people are going to need more help. And guess what, they do," she says.

Ms. Koons says that California was "very visionary" in starting the program 28 years ago. "Maybe back then, they didn't have all the data to know why and how this was important, but now all the data is coming out to say this population needs more care coordination. That is what our program is designed to do," she says. "It shouldn't be a surprise to anyone."

About 90% of MSSP recipients rely on IHSS services, notes Ms. Navarre. "So if the legislature is going to be considering reductions to IHSS, then we suggest they consider maintaining the infrastructure of MSSP for these highly impaired recipients," she says.

Impairment levels range widely for IHSS recipients, says Ms. Navarre, while MSSP requires that participants quality for placement in a skilled nursing facility.

Ms. Navarre says that it's simply not possible to know how many of the MSSP recipients would actually go into a skilled nursing facility if the program ended. "It depends partly on their level of impairment, but based on their personal choice, they may not end up going," she says. "It is hard to predict who would actually end up costing the state money."

A side-by-side comparison of the cost of the MSSP program and nursing home care may be misleading, adds Ms. Navarre, because MSSP recipients are also accessing other community-based programs which

add to the cost of keeping them in the community. "The state doesn't have a system that tracks what other community-based services an MSSP recipient may be receiving, so it hard to even quantify how much someone is costing in the community," she says.

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Making the business case: "Night job" for MSSP staff

After the Multipurpose Senior Service Program (MSSP) was targeted for elimination in January 2011, the program's staff put together their own analysis to prove the cost savings achieved by the program, reports **Eileen M. Koons**, MSW, ACSW, director of Huntington Senior Care Network.

"Our fact sheet is based on the most recent data available, which was provided by the administration to the federal government," she says. "It calculates the break-even point. This was verified with a long-term care financing expert."

The analysis is based on the CMS 372, a publicly available cost comparison report required for Medicaid waiver programs. "It was a matter of finding a way to tell the story of the budget impact," says Ms. Koons. "The other story, of course, is the human impact."

While Ms. Koons agrees it's impossible to know exactly how many of MSSP's 11,000 participants will enter a nursing home if the program ends, she says it is possible to calculate the cost savings of the program.

"You can take the verified information on how much this program saves, and simply calculate how many people it takes, if the program were eliminated, before you stop saving and start adding to the deficit rather than reducing it," says Ms. Koons. "That number came out to 18%."

More costly services

Ms. Koons says that the program's end will drive many people into more costly services. She and her staff set out to do "everything possible" to educate legislators, the Governor's office, budget staff, and the community about this.

The efforts, says Ms. Koons, included surveying MSSP providers statewide to get a sense of the job loss entailed, doing an analysis of the negative economic consequences such as the loss of $20 million in federal matching funds, and also doing a lot of educating about MSSP activities.

"We have the added challenge of being a tiny little budget dust in the grand scheme of things," says Koons. 'We are also a program that serves a niche population and coordinates with other services. People who aren't really listening for the nuances can confuse us with other services that are available."

Ms. Koons says that defending the program's existence became a "night job" for staff in the network of 40 agencies. "We have had to spend an enormous amount of energy to see that people have a better understanding of what we do," she says. "It's not just the nice thing to do. There is a business case to be made for retaining these services."

These efforts did help some legislators to understand the program, according to Ms. Koons, but she is unsure whether this will make any difference in the end. "It's a scary time now. We have to assume and prepare for the worst, while hoping for the best and fighting like crazy," she says.

Meanwhile, the program is working with statewide partners to come up with alternative proposals, says Ms. Koons.

The number-one question now, she says, is what happens to the 12,000 participants if the program is cut. "We've never gone here before," says Ms. Koons. "Some may move in with family members, or a family member may quit their job to care for them, but for the vast majority, I don't know what the answer is."

If the MSSP program is eliminated, Ms. Koons says that she doesn't see it coming back. "Once California has walked away from a nearly 30-year investment, a safety net for people as an alternative to nursing homes, that is a very expensive resurrection," she says. "Will this program come back in two years? I don't see that happening." ■

"Cash and Counseling" works, even with mental health clients

Adults with mental illnesses in the Cash and Counseling program had higher satisfaction, both with their quality of life and with their paid caregivers, compared to those receiving traditional Medicaid services, according to an April 2010 study done for the Substance Abuse and Mental Health Services Administration, *Self-Directed Care in Mental Health: Learnings from the Cash & Counseling Demonstration Evaluation.*

Participants also had fewer unmet needs, no more injuries or other adverse health outcomes than other recipients of services, no significant differences in total expenditures, and were able to successfully manage the cash option, the researchers found.

Data from the Cash and Counseling controlled experiment in Arkansas and New Jersey was ana-

lyzed, says **Kevin J. Mahoney**, PhD, one of the researchers. Dr. Mahoney is a faculty member at the Boston College Graduate School of Social Work and director of the National Resource Center for Participant-Directed Services in Boston.

"Many were dubious about letting persons with mental health disabilities manage their budgets for their home and community-based supports and services," according to Dr. Mahoney. "Our findings indicate these fears were largely unfounded." This was the case, he adds, as long as individuals had the ability to appoint a representative for the times they felt unable to manage alone, and received help from a financial management service with income tax filing, writing checks, and record keeping.

Dr. Mahoney says it was somewhat surprising that over 20% of the Cash and Counseling recipients had mental health diagnoses registered on their Medicaid claims data in the previous year.

However, Dr. Mahoney says the "big story" is that individuals with mental health diagnoses who were randomly assigned to the Cash and Counseling treatment group did much better on measures of quality of care and satisfaction than their peers who received care through traditional agencies.

These changes occurred without the need to increase costs, adds Dr. Mahoney. The individuals in the Cash & Counseling group were able to manage their own budgets, he says, with the option of hiring friends or family, and/or purchasing goods and services that helped them remain independent in the community.

The study's findings, says Dr. Mahoney, indicate that participant direction "can be a viable, productive option for persons with mental health diagnoses."

Growing trend?

Modest demonstrations where individuals with mental health needs can manage their own budgets for mental health services are under way in Florida, Texas, Pennsylvania, Oregon, Michigan, Iowa and Maryland, reports Dr. Mahoney. "There may be a need for a large controlled experiment before doubters will feel assured that the costs are the same or less," he says.

Dr. Mahoney notes that Section 2402a of the Patient Protection and Affordable Care Act calls on the federal Department of Health and Human Services to set internal policy on participant-direction that would cut across the population groups the department serves.

"This should spur interest in the mental health community, particularly given the changes health care reform made to the 1915 (i) Medicaid state plan authority," says Dr. Mahoney. "This may be a mechanism for states to secure federal Medicaid match for some services that were previously borne by the state alone."

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Medicaid underfunding nursing homes: Problem expected to grow

Medicaid programs underfunded nursing facility care by $5.6 billion in 2010, paying $7.17 per hour per patient, less than the nation's current minimum wage of $7.25 an hour, according to an analysis from the American Health Care Association in Washington, DC.

The December 2010 report, *A Report on Shortfalls in Medicaid Funding For Nursing Home Care*, identifies the states most affected by the rising pressure on state Medicaid budgets, both in terms of the highest aggregate Medicaid underfunding and highest per-patient per-day underfunding. The top six states are New York, Illinois, Massachusetts, Minnesota, New Jersey, and Wisconsin.

Joseph Lubarsky, president of Louisville, KY-based Eljay, which conducts the study each year, says he wasn't surprised by these findings, especially in light of the impact of the recession on state budgets. Severe budget shortfalls, he says, are making it difficult for states to provide adequate payments.

The enhanced federal matching funds and nursing home provider taxes, says Mr. Lubarsky, "saved the day for 2010 and 2011. Without them, it would have been much, much worse than it was. At least through 2010, there were still rate increases in most states that hovered around inflation, because of those two items."

While the economy is improving, says Mr. Lubarsky, revenues are not going up fast enough to cover deficits. "As we go forward, things are going to be real ugly," he says. "Most of the states for FY 2011 gave little or nothing. A lot of them are coming back now and saying we've got to do some major cuts," he says. "I think they are pulling their hair out to a greater degree now than at the time of the study."

Mr. Lubarsky says that the news is likely to get worse before it gets better. He notes that a chart included in the report shows that the percentage of costs covered by the rates tends to drop considerably during recessionary times.

"Then when things improve and states have more money, they pay a greater share of costs," he says. "During the last inflationary time in 2002 and 2003, we had a significant drop. I think it will dip even further before it rebounds."

Mr. Lubarsky says that Medicaid directors are thinking about how they pay for care and services, and many are looking into reforms such as bundled payments. "Many are going toward wanting to pay a price for service, but with that price there is a certain expectation of quality," he says. "Whether they can afford that is another question right now."

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Will increase in rates boost Medicaid primary care?

The federally funded increase in Medicaid primary care reimbursement rates, which requires providers to be reimbursed at parity with Medicare rates in 2013 and 2014, presents states with both challenges and opportunities, according to a January 2011 brief from the Hamilton, NJ-based Center for Health Care Strategies (CHCS), *Increasing Primary Care Rates, Maximizing Access and Quality*.

Tricia McGinnis, senior program officer at CHCS and the brief's lead author, says the increase will provide a big boost to Medicaid primary care. "As of 2008, the average Medicaid fee-for-service reimbursement rate was only about 66% on average of the rates paid by Medicare across the country," she says. "This will be a significant increase."

The expectation, says Ms. McGinnis, is that the new revenue will enable states to recruit additional physicians to participate in Medicaid, and provide more robust financial support to their existing network of primary care providers. This, she says, will potentially expand access to care.

The increase was included in the Affordable Care Act (ACA) in part to help with access issues, says Ms. McGinnis, since there will be up to 20 million newly eligible individuals coming onto Medicaid programs.

"There are a few challenges to implementation ahead," says Ms. McGinnis. One is that the Centers for Medicare & Medicaid Services has not yet released its regulations or any guidance to the states around how to implement this measure, she says, so states are watching closely to see how that evolves.

Several challenges

Ms. McGinnis notes that some states with payment models other than fee-for-service, like managed care or bundled payment approaches, will face some challenges in implementing the increase. "Medicare rates are based on the fee-for-service model, so bumping up to a managed care rate may be difficult for those states to do," she says.

The legislation applies only to physicians who are practicing family medicine, general internal medicine, and pediatric medicine, and Ms. McGinnis notes that this excludes nurse practitioners, physician's assistants, and certain specialists.

"Providers delivering family care services on the ground really go beyond just physicians," she says. "The legislation includes only a subset of practitioners providing family care. Because of that definition, it could be challenging to maximize the opportunity to increase access."

The broader challenge, says Ms. McGinnis, is that the provision only lasts between 2013 and 2014. "The need for this funding will not go away," she says. "It will be a challenge to sustain that funding beyond 2014."

Broader opportunities

Ms. McGinnis says that the increased primary care rate offers broader policy opportunities, beyond just increasing access. "For states that are exploring innovative approaches to payment, the low reimbursement rate is often a big barrier," she says.

The increased reimbursement is likely to encourage innovative approaches that align payment with quality of care, says Ms. McGinnis.

Some states have already implemented payment reforms around medical homes, notes Ms. McGinnis, and the primary care rate increase should encourage states to expand this approach as well as other innovations, such as Accountable Care Organizations.

"Those are delivery care innovations that don't rely on fee-for-service payment approaches," says Ms. McGinnis. "Depending on how the regulations are structured, this primary care revenue stream could really kick-start those innovations.

Ms. McGinnis notes that some of the provisions in the ACA offer matching funds and significant opportunities to curb costs. "So even cash-strapped states will be able to take advantage. For example, health homes is at a 90/10 match," she says. "Because these are innovations that could potentially bend the cost curve, states are much more willing to look at them."

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To strengthen primary care, leadership is key

Leadership and the convening of stakeholders, payment incentives, support for infrastructure, information feedback and monitoring, and certification and recognition are key factors for successful delivery system reforms, according to a December 2010 report from The Commonwealth Fund.

The report, *Strengthening Primary and Chronic Care: State Innovations to Transform and Link Small Practices*, highlighted several state-based initiatives utilizing local and regional strengths to reorganize the delivery of primary and chronic care to produce more efficient and effective care for patients and providers, particularly in small practices.

States can play an important role in helping practices of all sizes to transform, says **Anne Gauthier**, MS, one of the report's authors and a senior program director for the National Academy for State Health Policy.

They can do this by providing technical assistance and other resources, says Ms. Gauthier. This may include supporting practices in learning new methods of operating, what it means to practice team-based care, how they can be available for after-hours care, and how to improve coordination between the primary care practice and specialty care services.

"No physician wants to practice in a wasteful method. They are there to provide the highest quality care," says Ms. Gauthier. "They may need some assistance in learning how to achieve better quality and be more efficient."

Leadership is a critical element in states that are supporting primary care and helping transform practices, according to Ms. Gauthier. "They are not just looking for ways to save costs. They see clearly that there is evidence that new models of primary care provide better care, and have the potential for lowering costs," she says. "They see that as an investment that is going to pay off over the long term."

New payment models

There are many opportunities in the Affordable Care Act to strengthen primary care, says Ms. Gauthier. These include an increase in payments to Medicaid providers for primary care, training and workforce education funding, and the new Center for Medicare and Medicaid Innovation that will support new primary care models, notes Ms. Gauthier.

New payment models, says Ms. Gauthier, are "particularly exciting for states to take advantage of. The reach of a multipayer pilot, particularly in states with a number of payers or a very dominant private payer like Blue Cross, is that if state and the dominant carrier join together, they can send the same signals to the practices and can share in the cost," says Ms. Gauthier.

One of the paper's case studies reports on Pennsylvania's multipayer medical home program, which was rolled out in stages. "They started in one region and went to another, and as they did that, they learned what was working," says Ms. Gauthier. "One of the things they learned with respect to payment is to offer some shared savings at a fairly early stage in the program. That was very motivational to the practices."

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New option may jump-start health homes in Medicaid

Medicaid programs now have a new option to offer "health homes" to enrollees with chronic conditions, included in the Affordable Care Act (ACA). "The main reason we will see strong interest is that this is a population that is very high-cost, and often goes without needed care," says **Jocelyn Guyer**, co-executive director of Georgetown University's Center for Children and Families in Washington, DC.

The health home option is a "win-win,"says Ms. Guyer, because it creates the potential for both significant savings and better care.

"There might be some short-term savings, in part because there is such generous federal funding for the first couple of years," she says. "Then in the longer run, it has the promise of changing the way states deliver care to this population."

While short-term savings are likely to be modest, says Ms. Guyer, significant savings should result over the long term if states do a better job of delivering care.

States grappling with dire budget situations, though, may not be able to take on a new and innovative project even if it has the promise of savings, adds Ms. Guyer. "States are so beleaguered at the moment with their budget situations," she says. "They often don't even have enough bodies on the ground to do the basic functions of Medicaid."

However, states may take a limited approach just to get started, says Ms. Guyer. "If states can't bite off the whole thing, they may take a smaller bite," she says. "There may be particular conditions that are just so expensive that it makes sense to use the very limited resources states have to try to set up health homes in those cases," she says.

Smarter savings

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The challenge, says Ms. Guyer, is for states to achieve savings without resorting to cutting services. "There is no question that the budget situation continues to be serious. The challenge will be to find smarter ways to achieve savings that don't involve cutting tens of thousands of people off coverage," she says. "It's easier to cut adult dental benefits than to start up health homes."

Ms. Guyer points to Health and Human Services Secretary Kathleen Sebelius' Feb. 3, 2010, letter to state governors, which acknowledges the seriousness of the budget problem and offers strategies to achieve short-term savings.

"While some involve cuts that would be harsh for beneficiaries, most would actually improve care, including the health home model," says Ms. Guyer.

The letter indicated that if a strategy appears to be working in one state, they would be willing to fast-track approval in new states, adds Ms. Guyer. "It's a very strong signal that they are willing to work energetically with states to find better smarter ways to achieve savings, without cutting people off," she says.

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