State Health Watch

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In This Issue

Will Medicaid penalties result in better health, or more uninsured?

The state of Arizona has proposed a $50 annual fee on childless adults in Medicaid who are obese or smokers.

At this point, the fee is being limited only to smokers who are not actively trying to quit, according to **Jennifer Carusetta**, chief legislative liaison for the Arizona Health Care Cost Containment System, Arizona's Medicaid program.

"The intent of this fee is to incentivize our members to make better health care decisions, while also reducing the health care costs that are associated with smoking," says Ms. Carusetta. "CMS is currently evaluating this proposal."

If it's approved, however, the fee isn't likely to raise much revenue, according to **Peter Cunningham**, PhD, a senior fellow and director of quantitative research at the Center for Studying Health System Change in Washington, DC, because there probably won't be many Medicaid enrollees willing to pay it.

"States are pretty desperate right now to try to find ways of saving money, or in this case raising revenues, on their Medicaid programs," says Dr. Cunningham. Since states aren't able to reduce eligibility, he

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PA Medicaid's EPCCM med home program saves $85M in four years

Without the cost savings generated by various programs, including a successful medical home initiative, Pennsylvania Medicaid "would have been in a much worse position than what we're in," says **David K. Kelley**, MD, MPA, chief medical officer for the Pennsylvania Department of Public Welfare Office of Medical Assistance Programs.

Fiscal Fitness: How States Cope

Over the past five or six years, says Dr. Kelley, "a whole host of programs" were put into place that generated significant cost savings for Medicaid, including a more robust pharmacy management program, a radiology management program, and the Access Plus Enhanced Primary Care Case Management (EPCCM) program.

"We weren't forced to do a lot of benefit cuts, but we are facing a pretty big budgetary hole," says Dr. Kelley. "In this governor's current budget, there will be some benefit reductions. These are very challenging times for us."

Current projections are for an

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Cover story

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says, they're looking for other ways to reduce Medicaid costs at a time when budgets are severely strained.

If the fee is approved, Dr. Cunningham expects that some states with lack of political support for the Medicaid program will follow suit. "The administration is under a lot of pressure to allow states some flexibility, but whether they will go for this or not, I don't know," he add.

While the Centers for Medicare & Medicaid Services (CMS) has the authority to waive certain requirements related to eligibility and cost-sharing, there is no reason to believe CMS can or will waive the minimum eligibility or cost-sharing thresholds for Medicaid, according to **Mark Trail**, managing principal at Health Management Associates in Atlanta. "Additionally, they will not waive the maintenance of effort requirements currently imposed by the [American Recovery and Reinvestment Act of 2009] and the ACA [Affordable Care Act]," adds Mr. Trail.

Arizona extended Medicaid coverage for groups who wouldn't otherwise be eligible under a waiver, explains Mr. Trail, and with the renewal of that waiver, have the opportunity to renegotiate certain terms. "For most other states, adding a 'premium' for smokers or folks with obesity to obtain Medicaid would be considered a change in eligibility standards, and therefore not permissible," says Mr. Trail.

Could fees reduce enrollment?

There is a lot of current interest in promoting wellness in the Medicaid program, says **Joan Alker**, co-executive director at the Georgetown Center for Children and Families and a research associate professor at Georgetown University's Health Policy Institute.

"That's a good thing, but the way Arizona is going about it is not the right choice. It's a very bad idea," says Ms. Alker.

Even a $50 fee is simply not affordable to many Medicaid beneficiaries who are living month to month and using their resources on bare necessities, says **Michael Perry**, a partner at Lake Research Partners, a Washington, DC-based national public opinion and political strategy research firm. "These fees sound little, but they are very large for Medicaid families, many of whom are still reeling from the recession," he says.

Inability to pay the fee could ultimately drive someone out of the Medicaid program, says Mr. Perry, thus increasing the rolls of the state's uninsured.

"When you consider the fact that you are talking about a mostly poor population, that could be a disincentive to continue," says Dr. Cunningham. "One could question whether maybe that could be part of the intent."

Arizona is one of the few states that has eligibility for childless adults, notes Dr. Cunningham, but they are not able to reduce that eligibility. "The problems of escalating Medicaid costs and really tight state budgets are real," he says. "It's not surprising that a state would try to find ways within the law to try to decrease the cost."

There is a lot of discussion in the private sector on the best ways to encourage healthy behaviors, says Dr. Cunningham, but efforts generally focus on rewards instead of penalties. "Is the fee going to get obese people to lose weight and adopt a healthier lifestyle? I'm very skeptical that's going to work," he says.

It's unclear whether incentives are very effective in general, adds Dr. Cunningham, and Medicaid

recipients in low-income neighborhoods lack healthy food options in grocery stores and restaurants. "You're not going to see a Whole Foods in the inner city, and even if there is, they're not going to be able to afford it," he says.

Instead of seeking to impose a fee for smokers, suggests Ms. Alker, the state should take the opposite approach. "A better way to cut Medicaid costs is to offer a $50 reward for quitting smoking," she says. "On the employer side, cash incentives have been shown to be effective in some time-limited situations."

The Affordable Care Act (ACA) offers incentives for Medicaid programs to prevent chronic diseases, adds Ms. Alker. "We have seen some guidance on this from [the U.S. Department of Health and Human Services]. In the context of the ACA, they did stress that grants are focused on positive incentives," she says. "This would not be one of those, clearly."

Many employers have imposed fees to encourage workers to quit smoking and other behaviors that could negatively affect their health, says Mr. Trail, adding that the state of Georgia has imposed additional premiums on state employees who smoke.

While Georgia's added premium did result in more employees taking advantage of cessation programs, adds Mr. Trail, it's not clear whether the participants actually stopped smoking. "The added premium would arguably reduce the cost to the state, but yet to be determined is whether it actually reduced health care costs."

Imposing fees for unhealthy behaviors can potentially cross the line of imposing a "pre-existing condition" impediment in front of someone, says Mr. Trail. "Where does it lead — to those who have high cholesterol and don't adjust their diet, or those who fail to wear sunscreen or get routine checkups?" he asks. "It seems we need to think about the carrots, and not so much the sticks."

The most promising models of care being implemented right now emphasize prevention and keeping patients out of hospitals, according to Mr. Perry. "Penalties on Medicaid beneficiaries are not the solution," he says. "Bringing some of these new models of care into Medicaid is a better approach."

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Fiscal Fitness

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increase in enrollment of around 4.5% throughout Fiscal Year 2011-12, which is a slightly less steep increase than for the previous five years, says Dr. Kelley. "Seven years ago, we were at 1.6 million. Now, we are at 2.2 million recipients," he says.

Revenues were slightly higher than projected for the last quarter, adds Dr. Kelley, but the state has an aging population, growing enrollment and expects rising costs over the long term.

"We have a lot of fiscal challenges," he says. "But some of the programs we put in place helped us keep our Medicaid program at the level it's been at for many years, without having to do huge cuts in benefits."

In fact, some minor increases in provider fees were made in previous years, including some evaluation and management, dental and early periodic screening, diagnosis and treatment codes. "Had we not had some of these cost savings, that would have been extremely difficult to do," says Dr. Kelley.

Access Plus EPCCM

The Access Plus program provides care management and coordination, either telephonic or community-based, for people with complex diseases. "In our current program, there are 21 disease entities that the Access Plus vendor is responsible for better managing and coordinating care," says Dr. Kelley. "There are several mechanisms by which they do that."

The program utilizes community nurses in 42 rural and suburban counties who contact consumers by phone or interact with them face to face. The nurses also work with primary care practices to identify care gaps, improve quality, and coordinate services. Consumers are directed to select a medical home that will help them to better coordinate their care, says Dr. Kelley, and refer them for appropriate services.

"We have books through our actuaries showing an $85 million savings over the first four years," says Dr. Kelley. "And that is after all of the costs of the program have been taken out, after paying our vendor and everything else." There has been a very significant improvement in quality over the first five years of the program, he adds, based on the state's measurements.

Over the first five years, the program has seen the below improvements in access to care, as measured by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS):

- Well child visits ages 3 to 6 (67.4% to 74.4%)
- Adolescent well care visits (53.3% to 58.9%)
- Cervical cancer screening (63.0% to 67.2%)
- Frequency of ongoing prenatal care (62.4% to 76.9%)

• Emergency room utilization visits per 1,000 member months (61.1% to 41.7%)

• Annual dental visit for children ages 2 to 21 (41.8% to 49.5%)

• Diabetes poor control (43.3% to 35.0%)

• Blood pressure control (59.1% to 68.4%)

The Access Plus program has been able to link consumers to a medical home, reduce emergency room visits, improve results related to chronic conditions, and save money, according to Dr. Kelley.

"It's not that we were in a great budgetary position, but we were willing and able to try out a new model," he says. "We have gotten a good return on that, both in terms of dollars saved and quality and access improved."

Broader population reached

In 2007, major insurers, providers, consumers and other stakeholders in Pennsylvania were brought together to develop a program to pay for improved care of patients with chronic conditions. This led to the implementation of Pennsylvania's multipayer medical home project, which is now in its fifth year, says Dr. Kelley.

The medical home program began as a pilot in southeastern Pennsylvania, and eventually was rolled out statewide in five different regions, each with a slightly different model, says Dr. Kelley, with more than 500 physicians currently participating. While other states have implemented multipayer medical homes, he adds, they haven't been doing so as long or at the same level as Pennsylvania.

During the initial rollout, the program gave incentives to practices to become accredited by the NCQA, says Dr. Kelley, and they were paid according to their level of NCQA accreditation.

"One of the common themes that goes across all regions in the collaborative are learning network sessions that the practices attend, where they are sharing best practices and results," says Dr. Kelley. Practices are required to report measures to a registry on a monthly basis, he explains.

The state's Medicaid managed care plans helped to fund the initiative, says Dr. Kelley, which ties in with Pennsylvania Medicaid's pay-for-performance programs for managed care organizations that aligns incentives with HEDIS numbers.

During the first three years, the program focused solely on adult diabetics and children with asthma. "We have been able to show fairly significant and sustained quality improvement around diabetes measures," reports Dr. Kelley.

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Focus groups showed lack of support for penalty-based systems

When West Virginia experimented with penalty-based systems that withdrew some Medicaid benefits if beneficiaries didn't comply with certain behaviors, focus groups were done to gauge the public's reaction to this.

"We found that it was very unpopular," reports **Joan Alker**, co-executive director at the Georgetown Center for Children and Families and a research associate professor at Georgetown University's Health Policy Institute. "Obviously, a focus group is not a poll, but people really didn't like it." This was true even for conservatives, who saw it as an unwanted government intrusion, adds Ms. Alker.

Medicaid clients were required to sign a contract stating that they'd adhere to certain behaviors, and if they failed to, their benefits would be limited, Ms. Alker explains. Participants in the state's Basic program who failed to adhere to the requirements were limited to four prescriptions a month, for example.

"It was very troubling to have an arbitrary limit on that, especially for children's coverage. What are you trying to achieve by cutting children off prescription drugs that they might need?" asks Ms. Alker, who authored a report on West Virginia Medicaid's program.[1]

In 2008, Ms. Alker evaluated Florida's efforts to incentivize healthy behaviors with its Enhanced Benefits Rewards Program. Credits of up to $125 a year were given to Medicaid clients for various activities, ranging from keeping doctor's appointments to participating in a weight management program.[2] The program has been done as part of a waiver for the past five years in several Florida counties, explains Alker.

"We found that the vast majority of credits were awarded for simple things, like keeping an appointment. Very few credits were awarded for more complex activities," she says.

During focus groups with Florida's Medicaid beneficiaries, Alker learned that very few of them were aware of the program. "There wasn't any evidence that the incentives changed behaviors, but that was in part because it wasn't a very targeted program," she says. "It was popular with beneficiaries when they learned about it."

To effectively encourage healthy behaviors, says Ms. Alker, states

need to be very clear on what behavior they are trying to change and in whom. "Remember that most Medicaid beneficiaries are children. So there is a question of whether you are trying to change children's behavior, or their parents' behavior," she says. "Unfortunately, a lot of times these discussions aren't concrete enough."

Penalties for obesity and smoking in Medicaid are not generally supported by the public, says **Michael Perry**, a partner at Lake Research Partners, a Washington, DC-based national public opinion and political strategy research firm, in part because people fear they could be imposed in private health plans next.

Rather, he says, the public supports more access to smoking cessation and nutritionists. "They also are more likely to support incentive programs and lower costs for those who improve their health," says Mr. Perry.

Polling on this topic is unreliable, adds Mr. Perry. "It is possible to frame this issue in such a way that you get a high number of people saying, 'Yes, let's impose a fee on people who receive Medicaid and who smoke or are obese,'" he says. "The knee-jerk response is to blame people who have Medicaid and who are obese and who smoke."

However, more thoughtful questions on this topic inevitably show people are uneasy with penalties on people who struggle with obesity or smoking, says Mr. Perry. They worry that such penalties are unfair to people who are trying to improve their health but cannot for genetic or other reasons, he explains, and that penalties could be imposed on them next.

"They do not like government interference in the lives of individuals, telling them what to do," says Mr. Perry.

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Do incentives, penalties work? Not much evidence to date

The idea of using a fee and incentive structure to motivate consumer behavior change, as Arizona is attempting to do with a proposed $50 fee on smokers and obese Medicaid clients, is certainly appealing, says **Donna Friedsam**, MPH, health policy programs director at the University of Wisconsin Population Health Institute in Madison.

"On the face of it, $50 does not seem a lot, as a marginal added fee for enrollment in a health coverage program," says Ms. Friedsam. However, it's unlikely that the $50 fee would achieve the health-related goals of the program, she says.

"Arizona may be attracting attention for its specific approach, but it is not the first state to try inserting incentives into Medicaid to address smoking, obesity, or other health behaviors of its members," she says.

West Virginia was perhaps the first state to experiment with penalty-based incentives systems that withdrew Medicaid benefits when patients did not comply with state behavioral requirements, notes Ms. Friedsam.

The state's Medicaid program made two levels of health care benefits available, contingent upon specified behaviors and compliance with a member contract, says Ms. Friedsam. Wisconsin, Florida, Idaho, and other states have pursued incentive-based programs, she adds, rewarding Medicaid members for achieving specific goals or meeting certain behaviors, particularly around preventive care.

"These programs have not yet demonstrated the utility of such incentives in promoting behavior change among the Medicaid members," says Ms. Friedsam.

A missed opportunity

While existing research suggests that small economic incentives may motivate short-term efforts, says Ms. Friedsam, these are particularly weak in achieving sustained weight loss or smoking cessation.

Penalties could actually deter current smokers from enrolling in health coverage and attaining the health care intervention that they need to quit smoking, according to Ms. Friedsam. "Research clearly demonstrates that people are most likely to break their tobacco dependence when provided with effective medications, as well as counseling and behavioral treatment," she says.

Obesity poses even greater challenges, says Ms. Friedsam, and existing health care interventions have demonstrated only modest success.

"The question here is whether it is reasonable to expect adults who are potential Medicaid beneficiaries to achieve individual weight loss, when these low-income persons face the greatest barriers to healthy food choices and active lifestyles," she says.

Medicaid clients often lack access to safe outdoor activity spaces, recreational facilities, affordable fresh

produce, and the time or knowledge to achieve lifestyle change, she explains.

Arizona's approach is most likely to simply deter enrollment by those with the lowest income who do not have a current health condition other than smoking or obesity, says Ms. Friedsam. However, she adds, these individuals will continue to incur expenses on the health care system on an episodic and uncompensated basis through hospital emergency departments and other safety net venues.

"The Medicaid program will have missed an opportunity to enroll them, and provide the preventive services that might have broken their tobacco dependence or helped avert or manage pre-diabetes, and thus avert later health care costs that will inevitably be borne systemwide," says Ms. Friedsam.

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Evaluation of multipayer medical home is under way

A formal scientific assessment of Pennsylvania's multipayer medical home program is under way, reports **David K. Kelley**, MD, MPA, chief medical officer for the Pennsylvania Department of Public Welfare Office of Medical Assistance Programs.

"We have done a less formal, less robust assessment," he says. "Anecdotally, we can say we think things look good, that we saved some money, but we can't objectively do that at this point. We just don't have the data."

During the first year or so, adds Dr. Kelley, the program's focus was mostly on practice transformation, with less emphasis on direct care management and transition of care activity. If significant cost savings aren't found, he adds, this may be the reason.

"Those are two things that we didn't make key pillars right out of the gate," he says. "We didn't require all of the higher-volume practice to embed care management nurses, and we didn't add a transition of care component."

Focus on transition of care

A first-year analysis by Keystone Mercy, one of the participating Medicaid health plans, did find some reductions in hospitalizations and ED visits, however, adds Dr. Kelley. "The same payer did another pilot with embedded nurses with a transition of care program, and found significant per member/per month savings," he says.

Last year, a transition of care program was added to the Access Plus Enhanced Primary Care Case Management program, says Dr. Kelley, involving nurses seeing patients while they are still in the hospital and following up with them after discharge.

"The whole goal is to get our consumers home safely, on the right medicines, and to see their specialists and primary care physicians," says Dr. Kelley. "Obviously, we are hoping to see some cost savings on avoiding readmissions."

A Pittsburgh-based Medicaid health plan, UPMC for You, has implemented a very similar program, adds Dr. Kelley, with embedded nurses and a transition of care program.

Dr. Kelley adds that it's worth noting that Keystone Mercy's assessment did show cost savings within a year. "It can be done within a year," he says. "But I don't want to put all eggs in one basket with the multipayer approach, and say that if we don't see cost savings then it was worthless."

In addition, Dr. Kelley notes that Geisinger Health System has published some encouraging results on their medical home initiatives in the Medicare population in the same 42 counties that Access Plus programs are in.

"There is a growing body of published literature, some of it maybe not as rigorous as we'd like it to be, that points to the fact that medical homes do add value, and save money and improve quality," says Dr. Kelley. The Access Plus program has clearly demonstrated that quality has improved, he says, and staff are now trying to translate that into cost savings.

Future directions

Enhanced funding available from the Affordable Care Act could motivate states to proceed with medical home initiatives, "but these are very challenging budgetary times. Coming up with that up-front cash is not easy to do," says Dr. Kelley.

While enhanced funding is a great "carrot" for states, says Dr. Kelley, there are also a lot of requirements attached to it. Pennsylvania's current approach, he says, is to continue to improve its medical home programs already in place.

One question, says Dr. Kelley, is whether this can be done with the participating managed care organization's existing capitation payments. "We think that it can be done," he says. "If we ask for the 90/10 [enhanced funding], then we are addicted to the 90/10 for two years. Our approach is to work within our current construct, but to really take it to the next level."

This will be accomplished, says Dr. Kelley by increasing the focus on transition of care and embedded nurses. "In the meantime, we are going to leverage our existing programs," he says. "We think we can do that without the 90/10, and without all of the strings attached to that." ■

Multiple Medicaid directives have agencies "three times as busy"

While South Carolina's governor has given a directive to find ways to spend money more productively in Medicaid, says **Tony Keck**, the state's Medicaid director, she has also given the directive to present credible alternatives to allow the state to opt out of federal health care reform.

"So while we are reforming Medicaid and looking for ways to drive costs out of the system, we are also presenting alternatives to opt out of health care reform because we think we have a better way of doing it," says Mr. Keck. "It's got us three times as busy."

Since there is no way to know at this juncture if those alternatives will be accepted, or whether health care reform will ultimately be ruled unconstitutional or be repealed in Congress, says Mr. Keck, the directive is to prepare just in case all or part of it gets implemented.

"It is prudent, because nobody knows what is happening," he says. "There is so much uncertainty. Every state is in the position of having to do all these things at once, and we don't know what's going to happen."

As a result, says Mr. Keck, agency staff are being diverted from other tasks. "We are certainly having to divert resources from things that we used to do," he says. "In some cases, we are taking advantage of outside dollars." South Carolina Medicaid recently received a Work Strategies grant from the Ford Foundation of several hundred thousand dollars, he notes, to improve its eligibility and enrollment process.

States' needs differ

"While states are in their biggest budget crunch ever, to have to do all of this on top of it is pretty tough," says Mr. Keck. "It's definitely putting a strain on us, and every other Medicaid program I've talked to is feeling the same pressure."

The agency's management staff are being reorganized to improve productivity, adds Mr. Keck. "We found out our manager-to-staff ratio is about one to four, and we're working on making it closer to one to eight," he says. "By freeing up some of those folks, we can redirect them to more productive purposes."

Mr. Keck says that one of his biggest concerns is that "everything we do over the next several years will simply become a reaction to what the federal government is telling us to do. There is a danger of us constantly responding to what the feds are throwing at us, instead of working on things that we should be spending time on."

South Carolina's needs differ from other states, he adds, with different issues that affect the health and well-being of its citizens.

The state's needs are much more related to endemic poverty and lack of jobs and education, according to Mr. Keck, compared to a state such as Massachusetts, which has a high level of education and a small percentage of poverty. "It's not all related to how can we simply get more health services, but how do we make investments in K-12 and higher education and bring more businesses to the state, so people can get better jobs," he says.

A good example, says Mr. Keck, is the Health Insurance Exchange planning grants, which he says were set up to answer the question, "Should we implement a state or federal health exchange? But sometimes the biggest danger is asking the wrong question," he says. "As we started to talk about this, we realized that what we really were trying to achieve is better outcomes in the private health insurance market."

The state launched its planning effort to ask that broader question that goes to the root of the problem, says Mr. Keck, instead of presupposing that the state should implement exchanges.

Employers dropping coverage

While revenue is now ticking up, Mr. Keck says South Carolina's Medicaid program, which currently covers 800,000 individuals, is still seeing increases in enrollment that are lagging behind the improving economy, with low-income families as the fastest-growing category. The budget for Fiscal Year 2012 projects about 39,000 people will be added to the Medicaid rolls, says Mr. Keck, an increase of 4.7%.

Mr. Keck adds that he is very concerned about reports from the state's actuaries indicating that about 145,000 individuals will drop their private health insurance and go onto Medicaid as of 2014. "That makes absolutely no sense," he says. "One of the fallacies out there is that poor people don't care about their own health care, but employers are dropping coverage."

Mr. Keck says that he expects to see more than 500,000 new enrollees coming onto the program in 2014. "In poor states like South Carolina, that is a huge burden," he says. "While the first two years are paid completely by the federal government, we've got to think more than two years out." ■

High-cost Medicaid clients move out of fee-for-service into managed care

Elders and adults with severe disabilities have mostly remained under traditional fee-for-service Medicaid plans, but this is now changing, according to **Thomas L. Johnson**, BA, JD, president and CEO of Medicaid Health Plans of America, a Washington, DC-based trade association representing Medicaid health plans.

A number of states are now moving their most expensive Medicaid populations, including dual eligibles, into some type of coordinated care arrangement, says Mr. Johnson.

A new Alignment Initiative was announced in May 2011, to be led by the U.S. Department of Health and Human Services' (HHS) Medicare-Medicaid Coordination Office. With new access to data on how Medicaid populations use Medicare services, states can identify high-risk and high-cost individuals, determine their primary health risks, and provide comprehensive individual client profiles to tailor interventions, according to HHS.

"The alignment initiative by HHS will give those programs a lot of assistance in coordinating care for this population," says Mr. Johnson.

Many dual eligibles still receive fragmented care, explains Mr. Johnson, but integrated care coordination is a better approach for treating the low-income, elderly and disabled patients that make up the dually eligible.

The cost of dual eligibles is almost half of the cost of Medicaid, notes Mr. Johnson, even though the population tends to be under 20% of total enrollment. "Coordination for the dual eligible population is part of the solution to the ongoing struggle Medicaid programs are having with their costs," he says. "It is an alternative to reductions in eligibility or cuts in provider payments."

The clinical needs of the dual eligible population are a lot more challenging than the traditional Medicaid population, who are likely to have chronic conditions and mental health disorders, says Mr. Johnson.

"You're starting to see states actually including this population in the RFPs they are producing over the next few years, or issuing separate RFPs for their long-term care dual eligible population," says Mr. Johnson.

RFPs need to be tailored to the particular needs of the state, says Mr. Johnson, since the size and needs of the dual eligible population and the availability of certain types of providers may differ. There is an emphasis on making sure that families are involved with care planning, he says, and giving individuals freedom of choice on staying in an institution or at home.

"We are seeing that with the RFPs being issued," says Mr. Johnson. "States want to be sure that health plans have the capacity to deal with the special issues that this population brings."

Fee-for-service "exceedingly inefficient"

Many of the states extending capitated Medicaid managed care to the Aged/Blind/Disabled (ABD) and Supplemental Security Income (SSI) populations are also looking at managed care options for dual eligibles, reports **James Verdier**, a senior fellow in the Washington, DC office of Mathematica Policy Research, a nonpartisan research firm.

The main reason for this, says Mr. Verdier, is that this population accounts for the majority of costs in Medicaid programs. "The costs are not with your basically healthy moms and kids population. Most of that population has already been enrolled in managed care," he says.

Most of the ABD/SSI population gets care from the Medicaid fee-for-service system, says Mr. Verdier, "which is exceedingly inefficient and costly."

However, when Medicaid programs do switch this population to managed care organizations (MCOs), says Mr. Verdier, they won't see savings over the short term. In part, this is because many people have serious health care needs that weren't being met in the fee-for-service system, he explains.

"Either there was not appropriate access, or care was so poorly coordinated that they were in really bad shape," says Mr. Verdier. "When they come into the MCO, their unmet needs are costly in the short term."

Savings tend to occur after a year or two, says Mr. Verdier, due to reductions in inappropriate hospital and emergency room services, and more appropriate use of prescription drugs. "The question for health plans and states and everybody else, is when do the savings down the road start to become larger than the up-front costs? That probably doesn't happen any sooner than the end of year two," he says.

It could happen before that, says Mr. Verdier, or, if the plans are not very effective in improving care, it may not happen for a very long time or at all. "My view is generally that the fee-for-service system is so bad for most beneficiaries in these eligibility categories that almost any kind of reasonably good managed care has got to be better," he says. "The fee-for-service system sets a very low bar."

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States need "track record" for move to managed care

Plans' lack of experience is one concern as states move their Aged/Blind/Disabled (ABD) and Supplemental Security Income (SSI) populations into Medicaid managed care, according to **James Verdier**, a senior fellow in the Washington, DC, office of Mathematica Policy Research, a nonpartisan research firm.

Although a number of multistate plans that specialize in the Medicaid managed care market have experience dealing with the ABD/SSI population, says Mr. Verdier, most have covered primarily mothers and children.

"That is one concern that has inhibited the expansion of this kind of managed care," he says. "You want people with a track record with this more complex population."

Here are Mr. Verdier's recommendations for steps that states should take when moving this population into managed care:

• **The RFP should be very explicit about the qualifications a plan needs to be a qualified bidder.**

For instance, says Mr. Verdier, states should specify the type of staffing that a managed care organization (MCO) needs to coordinate care for people with especially complex care needs.

• **The system of payment for the plans should be appropriately adjusted for the high needs and high risk of this population.**

Some people may have several coexisting conditions with extremely costly care, Mr. Verdier explains, while others may have a physical disability but are otherwise healthy and high-functioning. "There is enormous variation in the cost, and you have to take that into account," he says.

• **The state should be able to measure the quality of the care provided by the MCO.**

"You've got to have safeguards and monitoring provisions in place before you go down the road of including this population in managed care," Mr. Verdier says.

• **Beneficiaries and their advocates should be consulted.**

"You can't simply rush the thing through without consulting the people whose lives are going to be affected by it," says Mr. Verdier.

One approach, says Mr. Verdier, is to guarantee that beneficiaries can see the same providers they have seen in the past even if they're not in the MCO's network, at least for a transition period. "This makes sure that people with pretty complex needs do not have their lives disrupted, and gives everyone time to develop alternative arrangements if necessary," he says.

• **Concerns of providers should be addressed, especially providers of mental health services, long-term care, and personal care assistance.**

These providers are typically concerned about the additional layer of management and oversight that a managed care plan is likely to bring, says Mr. Verdier, and that they won't be paid as much for particular services or that there will be constraints on the volume of services they provide.

"A number of states require that the managed care plans pay the same rates that providers have been getting in the fee-for-service Medicaid program," says Mr. Verdier. "It wouldn't necessarily continue in perpetuity, but it is a way of dealing with the transition."

To assuage the concerns of providers of home and community-based services, says Mr. Verdier, some states require managed care plans to contract with them.

"You can require the plan to at least offer these providers a contract under reasonable terms, and they can take it or not as they see fit," he says. "It is an assurance that they will not be shoved to the side." ■

Data show palliative care saves Medicaid money, improves care

Medicaid patients facing serious or life-threatening illnesses incurred $6,900 less in hospital costs if they received palliative care, compared with a similar group of patients who received usual care, according to a new study[1]. Palliative care recipients also spent less time in intensive care units (ICUs), and were more likely to receive hospice referrals.

Based on these findings, the researchers estimate that the Medicaid hospital spending in New York state could be reduced by $84 million annually, if every hospital with 150 or more beds had a fully operational palliative care consultation team.

"Over the past ten years, we have seen the rapid growth and development of palliative care teams in hospitals. They are focused on improving the quality of life for persons with serious illness and their families," says **R. Sean Morrison**, MD, one of the study's authors and a professor of geriatrics and palliative medicine at Mount Sinai School of Medicine in New York City.

Given the fact that palliative care teams are focused on the most complex, seriously ill patients, which

are the 10% of the population that accounts for 50% to 60% of total Medicaid costs, the researchers wondered if this would result in cost savings to hospitals, says Dr. Morrison. They decided to focus on Medicaid beneficiaries because of the rapid growth in Medicaid spending, he explains, and because Medicaid covers a vulnerable patient population.

"If you can improve quality and lower costs for Medicaid patients, this would have significant benefits for other populations served by those hospitals," says Dr. Morrison.

The researchers selected four New York hospitals with mature palliative care programs, and found significant reductions in overall hospital costs, ICU expenditures, and ICU deaths, and increases in referrals to hospices.

These findings, combined with other studies that have looked at cost savings of palliative care, show that care of this population can be improved in a cost-effective manner, says Dr. Morrison.

Better quality, less cost

"Palliative care programs essentially shift care of complex, seriously ill patients back into the community, which is where most patients want to be and where they tend to be much safer," says **Diane E. Meier**, MD, FACP, director of the Center to Advance Palliative Care at the Mount Sinai School of Medicine in New York City. "They make sure they get the services and support they need to remain at home."

The quality of care improves and costs are reduced, says Dr. Meier, because the hospital is by far the most expensive and high-risk setting for patients with serious illness. "Most of the reason they end up in hospitals is because there is simply no alternative safety net in the community," she explains.

Most admissions to the hospital occur through the ED, she says, and patients often turn to the ED because there is nowhere else for them to get care. "Our health care system is overbalanced on the hospital side, and underbalanced on the community side," says Dr. Meier.

Palliative care teams mobilize existing resources in the community to meet the needs of these typically very complex patients, she says, and the needs of family caregivers who are often exhausted and overwhelmed themselves.

"The result of that, not surprisingly, is that many crises are averted. Patients do not end up having to go back to the hospital," says Dr. Meier. ■

Palliative care model meets goals of health care reform

All of the accountable care principles that are integrated into the Affordable Care Act (ACA) require a clinical approach to the sickest, most complex and costliest patients, says **Diane E. Meier**, MD, FACP, director of the Center to Advance Palliative Care at the Mount Sinai School of Medicine in New York City, because they all begin to move the system away from the fee-for-service model.

"Health care groups, providers, hospitals and multiphysician practice groups will need to function in an environment that involves various forms of capitation, where payment is linked to quality and not quantity of care," she says.

Palliative care is one of very few interventions that has repeatedly been shown to save money by improving the quality of care, Dr. Meier says. "It doesn't save money by rationing care, but by helping to avoid preventable crises," she says.

For this reason, says Dr. Meier, the new delivery and payment models called for in health reform have the potential to "enormously increase" attention to access and capacity for palliative care in Medicaid. "It's not explicitly called for in the law, but I don't see how any of these models can survive without it," she says.

A missed opportunity

The ACA's failure to mandate that palliative care be included in accountable care organizations (ACOs) was a "missed opportunity," says **R. Sean Morrison**, MD, a professor of geriatrics and palliative medicine at Mount Sinai School of Medicine in New York City.

"Within ACOs, it's going to be the 5% to 10% of the seriously ill patients that will account for the majority of health care spending," he says.

Including palliative care teams within the ACOs would ensure that a vulnerable population would receive the best quality care, says Dr. Morrison, and would also ensure that ACOs would be sustainable moving forward. "One of the things that states should be cognizant of is to make sure that ACOs and Medicaid medical homes include palliative care," he says.

Dr. Morrison says the "last untouched frontier" where palliative care has not been developed is long-term care facilities such as assisted living and nursing homes. "Right now, many Medicaid regulations are designed to encourage a system where seriously ill patients from nursing homes are transferred back and forth to hospitals to receive unwanted and unnecessary interventions, then sent back to the nursing home," he says.

For this reason, says Morrison, palliative care needs to be developed for the dually eligible elderly and disabled population residing in nursing homes. "This is a generalizable model that really meets the goals of health care reform," says Dr. Morrison. "It improves quality and reduces costs at the same time."

Barriers still exist

Dr. Morrison notes that only 60% of U.S. hospitals have some sort of palliative care program currently. "We need to move to fully integrating this into the fabric of our health care institutions," he says. "If we can do that, we improve care for our most vulnerable and costly population. We also have more dollars to go around."

One key barrier is reimbursement, says Dr. Morrison, as the physician and nurse practitioner are the only providers on the palliative care team who are currently reimbursed. "The other barrier is a workforce issue," he says. "It is a relatively new specialty. There need to be training opportunities for health care professionals to enter the field."

There is currently a cap on the number of graduate medical education trainees, he explains, and since palliative care is a new specialty, there are no new open training slots.

Some providers wrongly believe that palliative care is the same as end-of-life care, says Dr. Morrison, when in fact it's provided at the same time as disease-directed and curative treatments. Due to that misconception, he says, many patients are never referred.

"If I was a Medicaid director, I wouldn't want any of my beneficiaries being cared for in a hospital that doesn't have a palliative care program," says. Dr. Morrison. "State Medicaid directors can have a huge role in promoting education on palliative care for practitioners, as part of licensing requirements, for example."

Dr. Meier notes that Medicaid redesign laws were recently passed to require hospitals, home care agencies, assisted living facilities and nursing homes to ensure access to palliative care in New York state, adding that almost all payers who participate in Medicaid also participate with other payers such as Medicare and commercial insurance.

"By saying , 'If you want to participate in Medicaid, you must assure access to this kind of care for patients,' it's the same thing as saying that every health care institution needs to do this," she says.

Dr. Meier adds that the budget crisis was a key motivator for the legislation. "Everybody knows we are in a cost crisis," she says. "That has a way of overcoming a lot of barriers that ordinarily would prevent this kind of law from passing."

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REFERENCE

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Indiana and CMS clash over denying taxpayer funding to Planned Parenthood

As a result of the Indiana legislature voting to cut off $3 million in federal money from Planned Parenthood because it provides abortion services, the state's Planned Parenthood clinics stopped treating Medicaid patients, but a June 24 federal district court ruling blocked provisions of the state law.

"As far as we know, what Indiana is doing is new," says **Rachel Benson Gold**, director of policy analysis and Washington office operations at the Guttmacher Institute in Washington, DC. "Efforts in other states to restrict family planning funding have dealt with whether the organizations can receive state family planning funds, and none have ever reached Medicaid," she says.

On June 1, Donald Berwick, administrator of the Centers for Medicare & Medicaid Services (CMS), denied Indiana's request to block agencies that use their own, private funds to provide abortion services from being able to receive Medicaid reimbursement for family planning services to individuals enrolled in the program.

In a letter to the state, along with separate guidance issued by the agency to all states, CMS said that although states may exclude providers in cases such as fraud or other criminal activity, they are not permitted to exclude providers "solely on the basis of the range of medical services they provide."

"The Medicaid statute specifically permits enrollees to obtain services from any agency that is qualified and willing to provide the care," says Ms. Gold, adding that the guidance specifies that states "may not exclude qualified health care providers…from providing services under the program because they separately provide abortion services."

The state has 60 days to appeal the CMS decision, and indications are that it is likely to do so, says Ms. Gold. "According to media accounts, failure to comply with the agency's decision could jeopardize more than $4 billion the state receives in federal Medicaid reim-

bursement annually," she says.

In this situation, "all of the legal protections paradoxically are on the state side," says **Sara Rosenbaum**, JD, chair of the Department of Health Policy at the School of Public Health and Health Services at The George Washington University Medical Center in Washington, DC.

"Beneficiaries have been deprived of access, but the state has legal protections against the denial of funds even as the secretary issues what is unquestionably a correct ruling," says Ms. Rosenbaum.

A state has due process protection under federal law, Ms. Rosenbaum explains, and can therefore refuse to concur with the U.S. Department of Health and Human Services (HHS)'s decision. "Unlike a court, which has injunctive powers and can hold things in the status quo while the merits are decided, the secretary lacks such powers," she says. "It could be years until the question of whether HHS is right or wrong in finding Indiana out of compliance is decided."

Is HHS within its powers?

"The whole point of Medicaid in 1965 was to open up a broad array of services to poor people," says Ms. Rosenbaum. "You can't cut off access to providers that are capable of performing a service, just because they do other things that Medicaid doesn't pay for."

While the state certainly has the right to contest the federal interpretation, Ms. Rosenbaum says that HHS was "well within its powers. This is an incredibly important issue that goes to the heart of the whole program. It has to step in at some point to protect the integrity of the program."

Other states are likely to follow suit, says Ms. Rosenbaum because they believe they have broad power to decide who is a qualified provider. "There never has been a case precisely like this one," she notes. While there have been many freedom of choice cases, says Ms. Rosenbaum, she's unaware of any that deal directly with the question of whether a provider can be kept out the program because it provides services that Medicaid doesn't pay for.

"If you think about it, every provider out there provides services that Medicaid doesn't pay for," she says, adding that the only question really should be whether the provider is capable of providing the service that Medicaid wants to buy.

"The freedom of choice policy is particularly great in the case of family planning, as evidenced by years of Congressional amendments clarifying a right of access," says Ms. Rosenbaum. "There is no service that is more emblematic of this than family planning."

Each time that Medicaid has been amended to allow tighter control over access, Congress has exempted family planning, notes Ms. Rosenbaum.

"I believe what the state has done here is unlawful, but that does not mean the state shouldn't have its say in court before losing its federal funding over it," she says.

Ms. Rosenbaum says that she feels equally strongly, however, that beneficiaries should have access to the same protection to stop a service from being withheld from them, until there has been a definitive ruling.

"The question is, is it legal? We don't know the answer to that yet," says Ms. Rosenbaum. "The state has the right to have its case heard before we know whether it's legal or not, but beneficiaries should have the same right."

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