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In This Issue

Better access to primary care decreases hospitalization costs

Hospitalization rates in Medicaid programs were lower in areas with a greater number of primary care physicians, and in states that on average provided more outpatient visits and paid more per outpatient visit, according to a study published in *Health Affairs*.[1]

"Overall, we take this to mean that state Medicaid programs with a more robust system of primary and outpatient care are able to provide better care management, and thus reduce avoidable hospitalizations," says **Todd Gilmer**, PhD, one of the study's authors and professor of health economics at the University of California-San Diego.

Dr. Gilmer recommends that Medicaid programs improve outpatient and primary care systems, and expand the workforce by incorporating lower-cost providers such as physician assistants. "Nurse-based care teams can manage some of the more common chronic conditions, while physicians can be reserved for more complex cases," he adds.

Low reimbursement, a limited supply of willing providers, and inadequate access to necessary support services are some of the

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Delaware targets inappropriate ER use and hospitalizations

When Delaware Medicaid attempted to implement co-pays, "we didn't get very far with our legislative branch on that," reports **Rita M. Landgraf**, secretary of Delaware's Department of Health and Social Services.

Co-payments of $3.65 were proposed for visits to medical/surgical centers, outpatient hospital services excluding urgent emergency department (ED) visits, physical, occupational and speech therapies, and all prescription drugs with a $15.00 maximum, says Ms. Landgraf, and co-pays for non-urgent ED visits were not going to be applied to children, pregnant women, individuals who are institutionalized and individuals receiving hospice care.

Fiscal Fitness: How States Cope

If the copays had been implemented, says Ms. Landgraf, it would have resulted in a savings of $1,870,000 to the Medicaid program, inclusive of both federal and state dollars.

One reason that the Medicaid cost containment measures were

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Cover Story

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problems with primary care access in Medicaid currently, says **Robin Clark**, PhD, director of research and evaluation for the University of Massachusetts Medical School's Center for Health Policy and Research in Shrewsbury.

"Demand is increasing, and the supply of primary care providers willing to accept Medicaid patients is limited," says Dr. Clark. "Low Medicaid payment rates discourage providers from accepting Medicaid patients and squeeze available time for physicians to spend with patients."

Pressure to cut rates

Low reimbursement rates is the leading reason given by physicians for not serving Medicaid beneficiaries, says Dr. Clark, and further cuts are likely to cause primary care physicians to reduce the percentage of their practice devoted to Medicaid patients.

"Larger practices affiliated with hospitals are likely to weather the storm, but the economics just don't work for small practices," he says. Even if primary care providers are spared from rate cuts, reductions in specialty areas may place additional responsibility on them to manage chronic conditions such as mental illness, Dr. Clark says.

Physicians perceive Medicaid billing and regulation practices as burdensome, says Dr. Clark, adding that Medicaid beneficiaries often have more complex and challenging health care needs than privately insured patients. Medicaid patients may require more management, coordination and patient supports, he says, such as transportation, interpreters, health educators, and care managers.

"These services are poorly reimbursed or unavailable in some locations," says Dr. Clark. In light of this, he says, many states are participating in demonstration projects such as primary care medical home initiatives, to improve access and responsiveness to patients' needs.

"Some of these demonstrations include payments to assist with care coordination and other support services," Dr. Clark says.

Monitoring is necessary

Medicaid directors can't know whether a new policy initiative is successful unless the outcome is measured, says Dr. Clark, but this kind of evaluation is often underfunded or neglected in times of financial stress.

Monitoring and evaluation are, in fact, critically important for making sure policies and practices are cost-effective, Dr. Clark emphasizes. "Ineffective and wasteful policies can easily become entrenched if they are not identified early," he says. "Virtually no one believes that we can deliver care of reasonable quality, or effectively manage health care costs, without a strong, accessible system of primary care."

While boosting payment rates to Medicare reimbursement levels may make it economically possible for physicians to continue serving Medicaid patients, this won't completely solve the primary care access problem, says Dr. Clark.

"Effective policies will address a range of issues that impact care," he says. In addition to improved reimbursement for practitioners, states must ensure that providers and patients have access to additional supports, including interpreters, better care coordination, access to specialty care, and transportation, says Dr. Clark.

"Some states are experimenting with ways to bundle payments for a range of services," he adds. "Others

are offering additional reimbursement to primary care practices for expanding care management."

Waste of resources

Barbara A. Horner-Ibler, MD, a physician at the Bread of Healing Clinic, a free clinic in Milwaukee serving uninsured employed individuals, says that limitations in eligibility and "unachievable spend downs" are the biggest problems she sees currently with primary care access in Medicaid.

Dr. Horner-Ibler's patients are mostly 40 to 64 years old without dependent children and are not disabled, so they don't qualify for the state's BadgerCare program, but are unable to purchase an insurance policy because they have chronic illnesses and limited income.

Most of her patients who do qualify for Medicaid, usually because they have been awarded disability, are given a very large spend down, she says. "We have several patients with $4,500 every six months or $3,000 every six months. We treat these spend downs like high-deductible plans," she says.

Patients don't access Medicaid because they cannot afford these costs, says Dr. Horner-Ibler, which ultimately results in higher costs due to hospital admissions for uncontrolled chronic illness.

Dr. Horner-Ibler says she sees fewer clinics and physicians accepting Medicaid, noting that about 70% of primary care physicians in Milwaukee are employed by the hospital systems. "Hospital clinics severely restrict the number of Medicaid patients," she says. "They won't allow uninsured patients to even make an appointment without a down payment of $350."

Dr. Horner-Ibler adds that she doesn't think the mandated primary care rate increase will be enough to encourage any of the hospital systems to increase their primary care access to Medicaid patients. "Perhaps the [Federally Qualified Health Centers] will increase their capacity, but they are the clinics which already have six-week delays for employment and school physicals," she says.

One patient told Dr. Horner-Ibler that he goes to the emergency department every six months and falsely reports chest pain in order to reach his spend down, because the medical home he goes to won't see him unless he has reached the spend down limit.

"Of course, he is unable to pay the spend down. Instead of the clinic stuck with the bill, the hospital is stuck. But what a waste of money in the system!" says Dr. Horner-Ibler.

Eliminating the spend down, or at least reducing it to a more realistic amount, would reduce the overall cost to the system, she says. "It would create healthier patients who don't wait for an ED visit — or create a fictitious one — to be able to access appropriate health care," she says.

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REFERENCE

1. Gilmer TP, Kronick RG. Differences in the volume of services and in prices drive big variations in Medicaid spending among U.S. states and regions. *Health Affairs* 2011; 30(7):1316-1324. ■

New initiative targets Medicaid's 2014 primary care rate increase

Six state Medicaid programs are currently coming up with strategies to maximize the benefits of the mandated primary care rate increase, as participants in *Leveraging the Medicaid Primary Care Rate Increase,* an initiative from the Hamilton, NJ-based Center for Health Care Strategies (CHCS).

The rate increase is an opportunity for states to bolster primary care, support payment reforms, and enhance beneficiary access to primary care, but it also presents significant operational challenges, according to **Tricia McGinnis**, senior program officer in charge of CHCS's initiative. The six participating states are Arkansas, Colorado, Minnesota, New York, Oregon, and Rhode Island.

"This initiative is designed to help participating states make the most of this opportunity," she says. "It will help them implement the increase in the most operationally efficient manner."

These steps will occur:

- CHCS will work with participants to incorporate the increase into payment reform initiatives, such as episode of care payments, value-based payments, and global payments to Accountable Care Organizations.
- Once CMS releases a Notice of Proposed Rule Making, participants will provide CMS with constructive feedback on the operational feasibility of the regulations, potential barriers to implementation, and how regulations can strengthen the positive effect of the increase on Medicaid pri-

mary care.

• CHCS will work with CMS and state participants to assess the impact of the rate increase on patient access, quality and utilization.

Avoid problems with access

"If states are unable to leverage the increase to expand primary care access, access issues could arise in 2014 as the number of Medicaid beneficiaries increase under health reform," says Ms. McGinnis. She gives these recommendations:

• **States should position the Medicaid rate increase to support broader policy objectives around payment reform and primary care access expansion.**

"The rate increase can be used to support improvements in the quality of care for existing as well as new beneficiaries," says Ms. McGinnis.

• **To avoid confusion, states should notify physicians about the rate increase, and provide information on which provider specialty types and codes are eligible for the increase and which are not.**

• **States should devise strategies to measure the effect of the rate increase, and make the business case to sustain it beyond 2014.**

"If states are not operationally prepared to implement the increase on Jan. 1, 2013, they are likely to see an increase in claims disputes from their primary care physicians," she says.

Expectations are higher

The federal primary care funds should be used to improve value "rather than pushing more dollars through our broken, procedure-based 'pay for volume' system," says **Jed Ziegenhagen**, rates and analysis director of Colorado Medicaid, noting that federal funding of primary care is limited to eight quarters.

"We hope to build a reimbursement system that demonstrates the value of increased primary care reimbursement plainly enough that it supports retaining the increased funding, even when enhanced federal funding disappears," says Mr. Ziegenhagen, adding that he expects to see better outcomes and reductions in the total cost of care.

William Golden, MD, MACP, medical director of Arkansas Medicaid and professor of Medicine and Public Health at the University of Arkansas for Medical Sciences in Little Rock, says the state is doing a "major evaluation" of how it pays for health care, with a specific emphasis on episodes of care.

"Our Medicaid program is currently solvent for at least another year or two, which is an unusual condition for a lot of Medicaid programs," says Dr. Golden. This has allowed for a statewide payment reform initiative to be implemented across all payers, including private payers like Blue Cross and Blue Shield Companies and United Healthcare.

"We want to come up with a coordinated scheme to try to bend the cost curve, not necessarily in terms of payment rates, but in terms of innovations in payments," he says.

Medical homes and using health professionals to the maximum of their professional capacities are two options, says Dr. Golden. While only 20% of physicians provide 80% of the primary care in Medicaid in many states, about 40% of physicians are providing the primary care in Arkansas.

"That is actually a pretty good ratio," says Dr. Golden, adding that primary care rates were once at parity with Medicare but have slowly deteriorated. "The increase in primary care reimbursement gives us a chance to increase the expectations for accountable care," he adds.

Results have been less than expected for some metrics, he explains, such as preventive management of chronic care conditions. "While we are offering higher rates for primary care, we would also like to increase our expectations, particularly with [electronic medical records] and other kinds of 'meaningful use' activities," he says.

Dr. Golden's expectation is that better primary care will result in fewer admissions, less duplication of testing, more judicious use of antibiotics and X-rays, and in general, less management of acute care and more long-term management of chronic diseases.

"We are also looking at better care at night and weekends. A lot of practices just have an answering machine saying, 'We're not here, we'll be back on Monday,'" he says. "We're going to be looking at greater access to after-hours care."

More support for reform

Minnesota is in the midst of several payment and care delivery reform initiatives, all designed to support the primary care infrastructure, reports **Jeff Schiff**, MD, MBA, medical director for Minnesota Health Care Programs. "By participating in the collaborative, we hope to develop policy to support and strengthen these initiatives," he says.

These include the Minnesota Health Care Home program, participation in the Advanced Primary Care Demonstration, and the Health Care Delivery System Demonstration, a Medicaid Accountable Care Organization model that provides alternative payment arrangements for providers, says Dr. Schiff.

"Minnesota also has an active cross-payer quality measurement system that supports and enhances these efforts," he says. "These initia-

tives are being implemented across both fee-for-service and managed care programs."

Most enrollees in Medicaid/Children's Health Insurance Program and MinnesotaCare, a 1115 waiver program, are in managed care, reports Dr. Schiff, and with the enactment of 2011 legislation individuals with disabilities will also be primarily enrolled in managed care.

The two major goals, says Dr. Schiff, are to build primary care provider capacity in health care home programs, and to integrate primary care, behavioral health services and services provided by community organizations.

"We hope to support the infrastructure to report out to providers on the quality and utilization of care they provide to state public program participants," adds Dr. Schiff.

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Fiscal Fitness

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not supported by the finance committee of the legislature is that hospital providers voiced that they would be put in a difficult position in which there would be no guarantee they could collect the co-pay, says Ms. Landgraf, but they would still have to provide the treatment.

"They framed it that it was cost-shifting onto them," she says, while others argued that costs were being shifted to a population that was already fiscally challenged. "The issue turned into a social debate," she says. "If we weren't going to do something across the board with the provider network, which there wasn't a political appetite to do, there was a feeling that we were only doing something to the population."

Under the agency's original proposal, says Ms. Landgraf, the hospital wouldn't be paid for the individual's fourth ED non-urgent visit. "The idea was that it would provide time to manage those individuals who have a tendency to use the ER for non-urgent care," she says.

Surplus of funding

When the co-pays were first proposed, the state's revenue situation appeared to be very serious, adds Ms. Landgraf, but the state later ended up with a surplus of funding. "I'm not sure how this would have played out if that had not been the case," she says. "People would have really been forced to address this from a budgetary perspective."

At the time of the governor's recommended budget proposal, the state was facing a projected $208 million deficit. "The political will did not seem to be there because the state revenues increased later in the year," says Ms. Landgraf. "The committee wished to continue to support the population with no service limitations or co-pays."

Co-pays were just one of the proposed strategies involving increased cost-sharing, says Ms. Landgraf. "We were trying to come up with strategies to cost-share across the board, but we presented things that were not Draconian in any way," she says. "We first did some research around it to see what other states were doing."

The agency's internal study found that 38 state Medicaid programs had implemented some type of benefit restrictions in the previous two years, such as cutting optional services or limiting the number of non-urgent visits to the ED, and those 45 states have some type of co-pay requirement, says Ms. Landgraf.

"We were approaching this with some evidence to back up what we were doing," says Ms. Landgraf. "But because the state found itself in a better situation relative to our revenue stream, everything remained status quo. Meanwhile, the Medicaid budget continues to grow with increased volume and inflation."

Misuse of the ED

Approximately 1,500 Delaware Medicaid clients use the ED for non-urgent care more than three times a year, which costs approximately $1 million in state funds, reports Ms. Landgraf. "Those 1,500 people aren't getting really good outcomes," she says. "If you are using the ER as your primary care doctor, you are going to be vulnerable and compromised from a health perspective."

Currently, the agency is looking at ED utilization data to look for patterns in these users, such as medical conditions or geographic regions. "It's not as though they don't have a primary care physician. On face value, it doesn't appear that people didn't have access to a doctor," says Ms. Landgraf.

It's possible that the patients are unable to get in to see the physician for some reason, even though he or she is accepting Medicaid patients, says Ms. Landgraf, adding that just because there are enough primary care physicians to cover the Medicaid population, it doesn't mean they will actually be seen. "If I find out that 500 individuals are going to one practice, that tells me something. Maybe I need to be having a conversation with that practice about problems with access," she says.

Ms. Landgraf hopes to work

with the University of Delaware's College of Health Sciences to support this population in getting care earlier and improving care coordination, and the agency will examine whether the high-utilizers are accessing other services of the state that provide case management, such as the Division of Substance Abuse and Mental Health.

"If they are not, maybe we need to facilitate involvement with other programs throughout our department," she says. "And if they are already a part of our system, both Medicaid and the partner agencies need to have an integrated approach to deliver care."

Proceed with caution

Costs and enrollment continue to spike in Delaware's Medicaid program, says Ms. Landgraf, with about 200,000 individuals currently enrolled of the state's less than one million population.

"I haven't even seen any leveling off," says Ms. Landgraf. "For us to be able to sustain this level of growth, which now represents 16% of the overall state budget, will be problematic."

The state's budget surplus came in part from the gross receipts tax, some of which involves one-time-only revenue dollars such as abandoned property fines, and other tax revenues, says Ms. Landgraf. The state ended up with a surplus of $364 million at the close of its fiscal year on June 30, 2011.

"From a very high-level perspective, it looks like Delaware is coming out of the recession ahead of some other states, although the economy continues to demonstrate extreme vulnerability" she says. "I will believe we are moving forward when I start seeing my benefits either stabilizing or going down, and I am not seeing that."

More than 135,000 people are on the state's Supplemental Nutrition Assistance Program, and these numbers continue to grow, adds Ms. Landgraf.

"The corporate financial statements are looking better, but that is not resonating yet to the ground level, where I am going to see it from a social services perspective," says Ms. Landgraf. "Until I see that, we have to proceed with caution, especially in the Medicaid program."

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Delaware Medicaid looks to contain long-term care costs

Delaware Medicaid's long-term care population is still primarily fee-for-service, and this population is very high-cost because many individuals are in facility-based care, says **Rita M. Landgraf**, secretary of Delaware's Department of Health and Social Services. In April 2012, this group will switch to a managed care organization, she reports.

In calendar year 2010, Delaware Medicaid spent $154.5 million total funds on facility-based care, compared to $21 million total funds on home and community-based care.

Changing to a managed care framework will allow the state to re-balance the long-term care system, says Ms. Landgraf, enabling a delivery and payment structure that will offer options in the delivery of care.

"We are looking at the continuity of care and building a community network, to allow people to get their care in place," she says. "We are looking to support people with in-home health care after being discharged from the hospital, so they don't have to return to the hospital."

The Centers for Medicare & Medicaid Services is offering incentives to do this, notes Ms. Landgraf, and the Medicaid program is partnering with hospitals that want to avoid penalties for patients returning too quickly after being discharged.

Converting the long-term population into managed care will contain costs, according to Ms. Landgraf, and also give the population what it wants, so individuals don't have to go to a nursing home level of care prematurely.

"That is important for Delaware specifically because of our demographic shift. We are one of five states with a fast-growing demographic of individuals 65 and over," she says. "That will bring some challenges for the Medicaid program."

Robust support needed

The goal is to develop a continuum of care with robust community support, and to incentivize managed care organizations with a capitated rate that includes this, Ms. Landgraf says.

"We believe we can better support the population in the least restrictive environment, rather than the only option being a nursing home," she says. "The current practice we utilize in long-term care is just not sustainable. The population is just too huge."

Previously, Ms. Landgraf was an advocate for the aging population to be supported in their community. "Now, I analyze it from a cost-containment perspective. That

doesn't mean that people don't get services that they need," she says. "It means that we are able to offer a menu of services, so they don't prematurely land in a higher level of care."

Ms. Landgraf says another pressing issue involves individuals having to sell their assets in order to qualify for Medicaid and get long-term care. "We force people into a level of poverty to get care they require. We have to rethink all of that," she says. "We need to leverage funding through supports, rather than creating a system where people have to become impoverished to get some level of care."

Another issue is reaching out to caregivers to meet their needs, says Ms. Landgraf, and looking at ways to pay them for the work they do. "It is going to be a paradigm shift and those things don't happen overnight," she says. "Things have to evolve to get to a better system of care that will result in better outcomes for the population, *and* be fiscally responsible." ■

Upcoming Medicaid decision likely to have sweeping impact

California has appealed a 9th U.S. Circuit Court of Appeals decision stopping a 10% provider rate reduction from going forward, with an anticipated decision by the Supreme Court by spring 2012, notes **Stan Rosenstein**, MPA, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director.

The decision will address one issue—whether providers and beneficiaries have standing under federal laws to enforce the requirements that Medicaid rates be adequate to ensure access, says Mr. Rosenstein.

"If the Supreme Court says that providers *can't* litigate, then obviously the provider litigation in federal court is thrown out," says Mr. Rosenstein. The state's legislature replaced the original 10% reduction with a 1% or 5% rate reduction in February 2009, adds Mr. Rosenstein, and parts of those rate reductions were enjoined, and parts actually went forward.

Then in March 2011, the legislature adopted a new 10% provider rate reduction, dependent on approval from the Centers for Medicare & Medicaid Services (CMS). "Those rate reductions, both the new 10% as well as the old 1% that is in effect, are under CMS review right now," says Mr. Rosenstein. "Providers in the state are waiting to see whether CMS will approve the 1% that was done first, and also whether they will approve the 10% reduction."

If the Supreme Court invalidates the 9th Circuit ruling, and CMS approves the rate reductions, says Mr. Rosenstein, providers' only remedy will be in state court.

With the 9th Circuit decision, only the states of the 9th Circuit were affected, says Mr. Rosenstein, but the Supreme Court ruling will affect the entire nation. Over 20 states have filed amicus briefs with the Supreme Court in California, he adds, and the National Governor's Association has come out in support of California. "States and providers are watching this very carefully. It really will be a landmark decision for Medicaid," says Mr. Rosenstein.

Case is "monumental"

Steve Hitov, general counsel for the Coalition of Immokalee Workers, says that when he argued a case before the Supreme Court years ago in which now-Supreme Court Justice Samuel Alito was his adversary, Alito argued on behalf of the government that the only remedy for a citizen confronted with government wrongdoing is to petition his or her elected representatives.

"So, we pretty much know how he will rule on this," he says. "If this comes out the wrong way, then citizens confronted with blatant disregard of the law by the government will have no other recourse than to write their Congressman."

That the Obama administration has decided to come down on the side of Justice Alito's argument is, in Mr. Hitov's opinion, "totally indefensible. The President taught Constitutional law, so there is no chance he doesn't understand what is at stake here."

Mr. Hitov, a former National Health Law Program attorney, says that the case "is a monumental one, but not only because of its implications for Medicaid. It is nothing short of a case about the rule of law in this country."

The outcome will determine whether citizens can challenge government noncompliance with the law or not, says Mr. Hitov. "It just happens to be a Medicaid case that raises this fundamental rule of law issue," he says.

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Could we someday see full federalization of Medicaid?

Interestingly, the Patient Protection and Affordable Care Act (PPACA) takes some steps toward federalization of Medicaid from both a philosophical and a financial perspective, says **Nicole Huberfeld**, an associate professor at the University of Kentucky's College of Law in Lexington.

"For the past 46 years, only the 'deserving poor' have been eligible for Medicaid. This categorization was a holdover from colonial, state-based concepts regarding which citizens were worthy of government assistance," says Ms. Huberfeld.

The PPACA enacts a major philosophical shift by making all citizens eligible for Medicaid as long as they meet federal poverty requirements, she says, with the federal government funding the newly eligible enrollees completely in the first few years of the Medicaid expansion.

"The federal government arguably has 'federalized' this newly eligible population, and would have funded them 100% forever if not for budgetary constraints," Ms. Huberfeld says.

The states that have challenged the constitutionality of the Medicaid expansion in the 11th Circuit litigation have not challenged the philosophical change in Medicaid, she adds, only the economic detriment that they believe will result from the expanded rolls.

"Over the years, various actors have proposed that the federal government take over Medicaid," Ms. Huberfeld says. "These proposals may have been politically feasible, but they have gone by the wayside in the larger debate about national health reform."

Benefits for beneficiaries

With federalization, Medicaid would no longer be the second largest budgetary outlay for the states, says Ms. Huberfeld, and fluctuations in medical access that Medicaid enrollees often suffer would diminish.

"States often must cut benefits in the very moment they face enlarged Medicaid enrollment," she explains. "This is poor timing, and dangerous to enrollees."

The program could be administratively simplified if it were federalized, adds Ms. Huberfeld, which would save time and money. "Enrollees would likely benefit from national standards being applied to their medical care. After all, a person with renal failure still needs a new kidney, whether or not the state's program covers the transplant," she says.

Currently, a low-income, childless, non-elderly and non-disabled adult in Utah might be able to get coverage for certain primary care services, but wouldn't be covered if he or she needed surgery to repair a fracture resulting from a motor vehicle collision, says **Laura Hermer**, JD, LLM, an assistant professor at the Institute for the Medical Humanities at University of Texas Medical Branch in Galveston.

"The same individual might get his care covered by Connecticut's Medicaid program, and nothing covered at all in Alabama," she adds. "These sorts of disparities are not rational, and ought not to occur in this country. Yet they are commonplace."

Even if state experiments to reform Medicaid are unsuccessful, it's still not very likely that Medicaid will be federalized, according to Ms. Hermer. "There are a number of reasons for this. First, many states would likely fight such a change," she says, noting that different states have very different notions of what it means to "reform" Medicaid.

"Reform to Vermont, for example, means quite a different thing than it does to Texas," she says. "Many states and politicians argue this is a good thing, because different states have different needs."

Although differences involve medical or coverage needs of varying populations to a small degree, Ms. Hermer says that the real differences are ideological, such as who deserves public coverage, what that coverage should consist of, and how it should be provided and funded.

There is no good reason for coverage variations from state to state, argues Ms. Hermer, but many states nevertheless guard their prerogative to control the structure and funding of their respective Medicaid programs.

"The fact that 26 states challenged the new federal standards for Medicaid under the Affordable Care Act speaks loudly to this," she says. "If it only boiled down to money, then depending on how we structured it, states needn't necessarily complain at all."

For instance, a national Medicaid program could be funded through a payroll tax as with Medicare, without extracting a cent from the states, says Ms. Hermer. "But it's not just a matter of funding. States and localities have historically had control over what their programs for lower-income residents look like," she says.

Additionally, numerous private players are involved in state Medicaid programs, notes Ms. Hermer. If states no longer have control over Medicaid, then states might lose the ability to determine funding for providers of all the goods and services that are necessary to provide and administer health and long-term care to their Medicaid populations, she explains.

Ms. Hermer notes that Wyoming, Texas and Indiana studied what would happen if they withdrew from the Medicaid program, shortly after the PPACA was enacted.

"The bottom line for most of them turned on the effect such a withdrawal and concordant loss of federal funds would have on their respective health care economies," she says.

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Access, integration top priorities for adults with mental illness

Medicaid beneficiaries who receive care for mental health or substance abuse have greater physical health needs and higher overall costs than other beneficiaries, indicating the need for better integration of physical and behavioral health care under Medicaid, according to *Providing Care to Medicaid Beneficiaries with Behavioral Health Conditions: Challenges for New York*, a February 2011 report from the Medicaid Institute at United Hospital Fund in New York City.[1]

Barriers for adults with serious and persistent mental illness who are on Medicaid include shortages of housing and community supports and inadequate outreach and engagement efforts, says **Michael B. Friedman**, adjunct associate professor at Columbia University School of Social Work and former director of the Center for Policy, Advocacy, and Education of The Mental Health Association, both in New York City.

Most adults with mental illness who are covered by Medicaid don't have a long-term psychiatric disability, notes Mr. Friedman. "Integrated treatment for them can probably be provided in the context of primary health care," he says.

However, for people with long-term psychiatric disabilities, integrated services often need to be provided in the context of behavioral health programs, says Mr. Friedman, at least for those who have access to services and use them.

"Others either cannot get services they might benefit from, or reject them," he says. "For them, expansion of service capacity — especially housing and outreach — is critical."

Goal of increased access

There is disproportionate physical morbidity and premature death among individuals served in the public mental health system, says **Charles Ingoglia**, MSW, vice president of public policy at the National Council for Community Behavioral Healthcare in Washington, DC, primarily due to preventable medical conditions such as cardiovascular, pulmonary and infectious disease.

"Increasing access to primary healthcare for this population is one of the most important policy priorities," says Mr. Ingoglia.

The Patient Protection and Affordable Care Act (PPACA) solidifies federal support for the Substance Abuse and Mental Health Services Administration's primary care/behavioral health integration program, notes Mr. Ingoglia, and includes dedicated funding for the expansion of community health centers and the services that they provide, including behavioral health services.

The PPACA also contains a number of delivery system redesign projects, Mr. Ingoglia adds, including healthcare homes and Accountable Care Organizations, and behavioral health conditions are explicitly mentioned in both cases.

"Persons with serious mental illness are mandatory populations for the Medicaid health home state plan option," he says. "Community mental health organizations are listed as eligible medical home providers."

These models will test the ability of healthcare providers to work together to manage the overall healthcare expenditures for a defined population, says Mr. Ingoglia. "The prevalence data related to behavioral health conditions suggests that these efforts will fail, if they do not adequately involve the treatment of underlying behavioral health conditions," he adds.

The most costly Medicaid cases involve individuals with co-occurring serious physical and behavioral disorders, including both mental and substance use disorders, notes Mr. Friedman, and this population is often not connected with the mental health system.

"Almost everyone agrees that managed care for the high-cost

cases, who are generally people with serious co-morbid conditions, is the way to go," he says. "This includes managing medication, as well as managing other forms of treatment."

The PPACA emphasizes integration of physical and behavioral health services via "medical homes" and "health homes," notes Mr. Friedman, but he is doubtful that medical homes will do much to improve service for people with serious and persistent mental disorders.

"They are fundamentally primary health care practices that will provide modest coordination with behavioral health care," he explains. "On the other hand, health homes are designed to be comprehensive managed care organizations. If New York is any example, they can and will be used specifically for the population of highest cost Medicaid cases."

For a couple of years, states will be able to establish health homes and get a substantial increase in the federal share of Medicaid, adds Mr. Friedman. "If it proves possible to engage those people who are the highest cost Medicaid cases *before* they develop acute disorders that require long inpatient stays, substantial cost savings should be possible," he says.

The big question, according to Mr. Friedman, is whether health homes will be successful in engaging the high-cost cases, which will require extensive outreach efforts rather than waiting for these individuals to come in for care on their own.

"Assertive community treatment teams have been effective in doing this, as have some case management programs," he says. "Whether a managed care entity will be able to do this remains to be seen."

Contact Mr. Friedman at (212) 851-2300 or mf395@columbia.edu and Mr. Ingoglia at (202) 684-7457 or chucki@thenationalcouncil.org.

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Participant-directed program saves $18 million

The foundation that was laid for the operation of Arkansas' Cash and Counseling demonstration and the Independent Choices program was "unique from the very start," says **Deborah Ellis**, a program administrator with the Arkansas Department of Human Services' Division of Aging and Adult Services. "It truly was a spirit of teamwork on all levels to implement this new program."

There was "tremendous enthusiasm on a national level," she says, from the Centers for Medicare & Medicaid Services (CMS), the Robert Wood Johnson Foundation, and the Cash and Counseling National Program Office.

"What made it most unique was the focus on the people that would enroll in this program, and not on the providers who would provide the service to the people," she says. The big question, says Ms. Ellis, was whether people would act responsively if given an opportunity to be in control of meeting their health care needs, or if they would be worse off.

While much flexibility is given to participants, she says, much is expected in return. "It is the people that I have encountered that have taught me my best lessons in state government," she says. "People can teach us a lot about the right things to do. Our policies have a direct impact on a person's quality of life."

For instance, the program helps family caregivers who provide the majority of in-home care, Ms. Ellis says, which in turn decreases high institutional costs. The Independent Choices program offered some people the ability to leave the nursing home and return home, she adds, and allowed others to avoid institutional care altogether.

"Offering a participant-directed program goes much further than the policies that mold the program," she says. "To me, it puts the 'human' in human services."

Participant-directed programs require the same continuous quality improvement plans as any other program, Ms. Ellis notes. "We are continuously seeking ways to improve the program," she says. "Participant-directed programs do not function well without a lot of human interaction in the operation of the program."

In fiscal year 2005, 15,309 adults received agency personal care services, and 1,433 persons had their personal care services met through the Independent Choices program, while in 2011 personal care agencies met the needs of 14,122 adults and Independent Choices provided personal care services to 3,368 participants.

One of the earliest trends that was first identified by the Cash and Counseling demonstration evaluator, Mathematica Policy Research, was that savings in long-term care costs was helping to off-set higher personal care cost, Ms. Ellis reports. A longer-term follow-up study showed that savings in long-term care would continue through the third post-enrollment year, with nursing facility use reduced by 18% over the entire three-year study.

In 2010, an Independent Choices staff person, Mr. Daniel Clark, repli-

cated the original demonstration cost neutrality criteria required by CMS, and added criteria to analyze institutional cost, she says. The analysis used data available through the Medicaid data warehouse, and covered state fiscal years 2005 through 2009.

The average institutional cost was $2,416 annually for each participant in Independent Choices, compared to $3,298 for those receiving agency services, according to this analysis.

The data also showed that while Arkansas spent 16% more on personal care services, the Independent Choices net expenditures were 14% lower on average, she adds.

"Those in Independent Choices program received twice the in-home personal care services, yet the net expenditure to Medicaid averaged 14% less," she says. "The overall state and federal savings were $18,551,518 during the time frame." ■

Many eligible to remain unenrolled even after Medicaid expansion

An estimated 23 million non-elderly Americans will remain uninsured after 2014, including 15 million eligible for Medicaid coverage, according to a March 2011 Congressional Budget Office report.

"The large number of eligible but unenrolled people with the Medicaid program has always been a problem," says **Michael Perry**, a partner at Lake Research Partners, a Washington, DC-based national public opinion and political strategy research firm.

There are many reasons for this, according to Mr. Perry, who has researched innovative Medicaid enrollment processes for the Kaiser Commission for Medicaid and the Uninsured in Washington, DC. "People still have knowledge gaps about Medicaid. They are unsure what the eligibility levels are, and even how to enroll," he says.

People who have lost jobs and their health insurance during the recession are new to public health programs, says Mr. Perry, and many never consider that they may be eligible for Medicaid.

"Many of the people in this income band have fluid incomes that vary from month to month. That makes it hard for them to qualify," he adds. "Many keep holding out for that next job, thinking that their period of being uninsured and unemployed will be brief and that they do not really need Medicaid."

The enrollment process itself for Medicaid is a barrier, according to Mr. Perry, and many people simply don't want to go through the effort if they don't believe they will qualify.

While schools do some promotion of Medicaid and the Children's Health Insurance Program (CHIP), state budgets don't allow for much Medicaid outreach these days, says Mr. Perry. "There really are not many TV commercials, billboards, or ads about these programs," he says. "People really need to seek them out."

Mr. Perry says that "embedding" Medicaid enrollers in community organizations and hospitals is a particularly effective way to reach people in need of insurance. "In some smaller communities where there are big layoffs or big companies shutting down, I have heard of Medicaid and CHIP eligibility enrollers being asked to come speak to employees about the programs and help them enroll," he says.

Mr. Perry points to Louisiana's approach, where food stamp applicants are asked if they have health insurance, and are given the option of having the Medicaid program process their application. "This is great, because it means the family only needs to fill out one application. They are automatically processed for Medicaid, too," he says.

Similarly, Marylanders who indicate that they lack insurance on their state tax forms are sent Medicaid applications, notes Mr. Perry, while Chicago's public school system identifies children who lack health insurance so families can be sent applications for Medicaid and CHIP.

"In Oklahoma, there is a newborn enrollment program. Uninsured infants are enrolled in CHIP or Medicaid, and assigned to a pediatrician, before they even leave the hospital," says Mr. Perry. "The key is to make enrollment as automatic as possible for families."

While most Medicaid enrollees are currently children because eligibility levels are typically too low for a working adult without children to qualify, says Mr. Perry, this is going to change in 2014 when millions of adults will qualify. "There will be a need to rethink outreach and enrollment strategies," he says.

State budgets are one big obstacle to streamlining enrollment processes, adds Mr. Perry, and many have old computer systems that need updating. "Collecting all of the paperwork needed to process a family in Medicaid is cumbersome and a barrier," he says.

States are looking into being able to pull current income information from other state databases to reduce the need for all of this paperwork, he says. "Many states are really looking to make the enrollment process more of an online experience, where people

can apply from their homes and just mail in paperwork," says Mr. Perry.

In addition, Mr. Perry argues that the Medicaid program should be "rebranded" to remove any negative associations or stigma. "The goal should be to make Medicaid more of a health insurance program and less of a poverty program, which it is now," he says. ■

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