State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

GAO expresses concerns about waivers and their quality control

According to a General Accounting Office (GAO) report, the Centers for Medicare & Medicaid Services (CMS) should ensure that state quality assurance efforts adequately protect the health and welfare of Medicaid beneficiaries covered under home and community-based service (HCBS) waivers.

The GAO also recommended strengthening federal oversight of the growing HCBS waiver programs. CMS generally accepted the GAO's recommendations, but voiced concerns about some technical aspects of the report.

But the senators who requested the report expressed great concern and called on Health and Human Services (HHS) Secretary Tommy Thompson to suspend HCBS waivers pending improvements in quality control. Many state officials and consultants contacted by *State Health Watch* expressed concern about the report and a possible overreaction by CMS that could hurt people receiving services under the waivers. Some of them shared success stories in terms of some state efforts to maintain a close watch on

*See **GAO** on page 2*

Debates over fee for service and managed care has states in quandary over how to do business

Hoping to head off suggestions in some financially pressed states that Medicaid should abandon managed care and return to a fee-for-service payment mechanism, the Washington, DC-based Association for Health Care Affiliated Health Plans (AHCAHP) is publicizing a study it funded that it says demonstrates "managed care does a better job of caring for Medicaid beneficiaries than traditional fee for service does."

Fiscal Fitness: How States Cope

AHCAHP executive director Meg Murray tells *State Health Watch* there have been rumblings in some states about a return to fee-for-service structures, and a desire on the part of her association to provide ammunition to people at the local level to use with their governors and legislatures to support continued use of managed care.

"We wanted to demonstrate that managed care is the best thing for Medicaid beneficiaries and also for states' financial coffers," she explains.

The study, *The 'Good Olde Days' of Fee-for-Service Were Not So Good*

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Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, brenda.mooney@thomson.com.

Editorial Group Head: Lee Landenberger, (404) 262-5483, lee.landenberger@thomson.com.

Editor: John Hope, (717) 238-5990, johnhope17110@att.net.

Senior Production Editor: Ann Duncan.

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GAO

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HCBS programs (**see related story, p. 4.**) The GAO reported that in the decade from 1991 to 2001, Medicaid long-term care spending more than doubled to more than $75 billion, while the proportion spent on institutional care declined. In that same time period, HCBS waivers grew from 5% to 19% of the expenditures. The number of waivers, participants, and average state per-capita spending also grew considerably. Every state except Arizona operates at least one HCBS waiver program.

But in the absence of specific federal requirements for HCBS quality assurance systems, the agency said, states provided limited information to CMS on how they assure quality of care in their waiver programs for the elderly. States' waiver applications and annual reports for waivers for the elderly often contained little or no information on state mechanisms for assuring quality in waivers, thus limiting information available to CMS that should be considered before approving or renewing waivers, the GAO said.

The issue matters, according to the GAO, because more than 70% of the waivers for the elderly the GAO reviewed documented one or more quality-of-care problems. The most common problems included failure to provide necessary services, weaknesses in plans of care, and inadequate case management. GAO cautions that the full extent of such problems is unknown because many state waivers lacked a recent CMS review, as required, or the annual state waiver report lacked the relevant information.

The GAO report complained that CMS guidance to states and oversight of the HCBS waivers are inadequate to ensure quality of care for beneficiaries. It faulted CMS for not developing detailed guidance for states on appropriate quality assurance mechanisms as part of the waiver approval process, and said that initiatives under way to generate information on state quality assurance approaches do not address the problem. In addition, it said, CMS has not fully complied with statutory and regulatory requirements that condition renewal of HCBS waivers on:

1. states submitting required annual reports that include information on state quality assurance approaches and deficiencies identified through state monitoring;
2. CMS' conducting and documenting periodic waiver reviews to determine whether states satisfied requirements for protecting the health and welfare of waiver beneficiaries.

States determine the types of long-term care services they want to offer under a waiver. They may provide a variety of skilled services to only a few individuals with a particular condition, such as those with traumatic brain injury, or may offer only a few unskilled services to a large number of people, such as the aged or disabled. The wide variety of services that may be available under waivers includes home modification such as installing a wheelchair ramp; transportation; chore services; respite care; nursing services; personal care services; and caregiver training for family members.

The GAO pointed out that according to a CMS-sponsored review, oversight of waivers often is decentralized and fragmented among a variety of agencies and levels of government, and there is rarely a single entity with accountability for the overall quality of care

provided by waiver beneficiaries.

The report said information that has come to CMS indicates states use a variety of mechanisms to protect the health and welfare of beneficiaries served by the waivers. They can include satisfaction surveys, on-site visits to beneficiaries, complaint systems, conformity with provider licensure, and other state standards, provider audits and visits, corrective action plans, sanctions, program manuals, case management reviews, and internal or external program evaluations. The report questioned the wisdom of not having specific guidance calling for uniform mechanisms and reports, and said that CMS regional offices and state audits have identified weaknesses in state oversight in 15 of the 23 waivers the GAO examined. In some cases, it said, waiver programs did not have essential oversight systems or processes in place.

CMS making some advances

GAO acknowledged that CMS has a number of initiatives under way to generate information and dialog on quality assurance approaches, but said these initiatives stop short of requiring states to submit detailed information on their quality assurance approaches when applying for a waiver or stipulating the necessary components for an acceptable quality assurance system. And CMS also is not holding its regional offices or the states accountable for oversight of the quality of care provided to individuals under HCBS waivers, according to the GAO. The agency said its audit of the 15 largest waivers demonstrated the extent of oversight weaknesses in these ways:

1. Four of the 15 waivers were not reviewed in a timely manner by the CMS regional offices but still were renewed.
2. Four of the 15 had no waiver review final report completed by the regional office.
3. Four of the 15 lacked a timely annual state report to the regional office; and seven of the 15 had annual state reports that were incomplete because they either lacked information on their quality assurance mechanisms or on whether deficiencies had been identified.

The GAO said that the current size and likely future growth in HCBS waiver programs that serve a vulnerable population, particularly elderly individuals eligible for nursing home placement, make it even more essential for states to have appropriate mechanisms in place to monitor the quality of care.

It recommended that CMS develop and provide states with more detailed criteria on the necessary components of an HCBS waiver quality assurance system; require states to submit more specific information about their quality assurance approaches prior to waiver approval; ensure that states provide sufficient and timely information in their annual waiver requests on their efforts to monitor quality; ensure allocation of sufficient resources and hold regional offices accountable for conducting thorough and timely reviews of the status of quality in HCBS waiver programs; and develop guidance on the scope and methodology for federal reviews of state waiver programs, including a sampling methodology that provides confidence in the generalization of review results.

Asked for comment on a draft of the GAO report, CMS affirmed its commitment to an ongoing responsibility, in partnership with states, to ensure and improve quality in HCBS waivers. CMS said the federal focus should be on assisting states in the design of HCBS programs, respecting the assurances made by states, improving the ability of states to remedy identified problems, providing assistance to states to improve the quality of services, and thereby assisting people to live in their own homes in communities of their choice.

"CMS generally concurred with our recommendations to improve state and federal accountability for quality assurance in HCBS waivers," the GAO said, "but raised questions about our definition of quality, how best to ensure quality in state waiver programs, the appropriate state and federal oversight roles, and the resources and guidance required to carry out federal quality oversight."

While the GAO did not suggest shutting down the waivers, Sen. Chuck Grassley (R-IA), who requested the report with Sen. John Breaux (D-LA), said, "These waivers should be put on hold until [HHS] gets a handle on the quality of care going to older and disabled Americans. Right now there's no accountability, and that's wrong."

Mr. Grassley and Mr. Breaux wrote to Mr. Thompson to say they applaud the intent of the waivers but were troubled by the GAO findings on quality oversight. They said they strongly agreed with the GAO recommendations and that it is "imperative that HHS review its current policies for guidance to the states and work toward guaranteeing that all Americans have access to quality long-term care in their homes and communities." They asked Mr. Thompson for a response that includes a detailed plan, including implementation dates, of how the oversight weaknesses identified in the report will be addressed.

[For the GAO report, go to: www.gao.gov. For the Grassley/Breaux letter, go to: www.grassley.senate.gov/releases/2003/p03r07-07a.htm.] ■

GAO report is 'worrisome,' according to state official

For Penny Black, the director of home and community services with the Washington Department of Social and Health Services, the GAO report, which is raising questions about quality assurance for Medicaid beneficiaries services by home and community service (HCBS) waivers, is worrisome for its potential impact on the programs, especially when political leaders say future waivers should not be approved until the quality issues are addressed. (**See cover story.**)

"If that call [by U.S. Sen. Chuck Grassley (R-IA)] to suspend the waivers is followed, it would stop many states in midprogress," Ms. Black tells *State Health Watch*. "That would be really troublesome."

She says that for states that have a state Medicaid plan, key elements such as licensing of home health agencies already have to be in place and thus it easily can be determined that those states are monitoring quality through licensure requirements.

Sophisticated state program

Ms. Black's agency maintains a quality program that experts have cited as one of the best in the nation. She refers to it as a "very sophisticated automated assessment process that addresses all aspects of clients' physical and social needs." A computerized assessment tool can flag high-risk clients and make recommendations for case managers to use in referring clients to needed services.

Algorithms built into the system can determine the hours and levels of care clients are eligible for and then identify choices that clients can make that fit within the eligible care. An automated quality assurance system can be applied against the assessment tool for a sample of the caseload to monitor policy compliance and code compliance. A subset of those audited receive in-person visits to determine if their condition is as it appears to be and whether services have been provided.

"We've come a long way in establishing and assuring a certain level of quality in case management," Ms. Black tells *State Health Watch*. "Case managers work with the providers to be sure they understand the service plan and what they are supposed to do."

She says the automated quality assurance effort started about four years ago and has been operating since 2002. A more sophisticated update is due in 2004.

The state knows the average cost of care in all settings, Ms. Black explains, and has determined that those who are treated in their home have the lowest cost (an average of $750 per month), while those in nursing homes have the highest average per-month cost ($3,600).

Many other state officials and consultants contacted by *State Health Watch* expressed concern that the GAO was focusing on improper methodology for assessing quality and didn't give sufficient recognition to what states already have accomplished.

Typical auditor approach

Jim Verdier, policy research analyst with Mathematica in Princeton, NJ, sees the GAO report as demonstrating the "typical GAO auditor perspective in terms of what should be done to ensure better quality in home- and community-based services. They think in terms of inspectors, reviewing documents, and ensuring that services have been provided and documented. I don't think that's the way to most effectively assess quality. There's been a lot of research sponsored by the Centers for Medicare & Medicaid Services [CMS] and others to look at how to measure customer satisfaction and type of services needed."

Mr. Verdier says that customer satisfaction should be an important part of any assessment and can be determined through beneficiary surveys and review of calls to complaint hotlines. He points out that a lot of home-care patients are reluctant to make complaints, so that systems have to be in place to address that problem.

"There's been a lot of research aimed at ensuring better quality of care," according to Mr. Verdier, "but it was mentioned only in passing at the end of the GAO report. But that's where the future of quality assurance is."

He acknowledges that inadequate attention has been paid to quality assurance issues, partially because quality is harder to assess when services are provided in the home. Thus, Mr. Verdier says, the GAO has done a significant service in calling attention to the problems that need to be addressed, but is off-target in recommending solutions to the problems.

He says he is skeptical of a call from Mr. Grassley to suspend the waivers until quality programs are tightened.

"Absent the waivers," he says, "people in nursing homes who could be better served in the community might not get services, and those already in the community might not get services. That would be worse than a situation with waivers in which people get the services they need but there may not be the best monitoring in place."

One problem, according to Mr. Verdier, is that many home- and community-based service providers are not always the most organized and oriented to a strong administrative infrastructure to provide the kind of review the GAO would want. "When I was a state Medicaid director, I sometimes wished providers would be better organized and give me better data, but the nature of the business still is that they don't always invest in administrative structure the way they should," he says.

Mixed reactions

Chuck Milligan, consultant for the Falls Church, VA-based The Lewin Group, says he has mixed reactions to the GAO report, recognizing that it's useful for GAO to take a look at waivers in programs that are growing rapidly, but also recognizing there has been a "tremendous increase" in quality assurance for home- and community-based services, with tools developed and best practice guides that all seem to have been ignored by the GAO auditors when they did their study. And there is a concern that GAO seems determined to look at the issue from a health care facility licensure model rather than looking into consumer autonomy, independence, and choice. "Many other assessment techniques are being used because of opposition to the licensure form of oversight because it can be intrusive and paternalistic," Mr. Milligan says.

Within the community of those who work in home- and community-based care, he says, there is a movement to accept consumer choice, allowing consumers to take risk with dignity by living in the community.

Mr. Milligan says Sen. Grassley's call for a moratorium "would be a significant setback. I hope that CMS will keep on top of the issue without suspending waivers."

Milligan agreed with GAO that it is important to delineate roles between the federal government and the states. States, he says, should submit and manage the waiver to incorporate a safety process reached through a consensus with consumers and providers.

"States should carefully think through how they want to exercise oversight," he says. "The federal role, then, should be to monitor that state assurances to consumers are fulfilled. The federal role should not be to impose a predetermined set of oversight measures."

States addressing problems

At the National Academy for State Health Policy in Portland, ME, senior program director Robert Mollica tells State Health Watch that states are addressing some of the weaknesses that GAO pointed out in its report. And CMS identified what he sees as some very realistic limitations on its ability to commit the staff and resources that would be needed to follow the GAO recommendations.

"I didn't see in the report anything on the impact of what states actually are doing," he says.

The issue of a large number of beneficiaries not getting authorized services is very complicated, according to Mr. Mollica.

He notes that often a worker shortage is a reason for not all patients getting the services they need or want. "If agencies don't have the workers, they can't deliver the care. It's true, however, that the more you invest in quality, the better the system will be."

He notes that consumers often define quality in terms of the control they can exercise over services and their ability to identify the services and providers that meet their preferences. "We need to balance what consumers prefer with what the federal and state agencies are required to ensure," he says. "We should be making sure that people don't deteriorate because the services they receive are ineffective, that beneficiaries are not put in danger."

Need for federal expectations

John Williams, long-term care financing unit director for the Utah Department of Health in Salt Lake City, and a member of the National Association of State Medicaid Directors' long-term care technical advisory group, says that, overall, GAO's observations in the report are pretty factual and on target. "I agree with the CMS response that program performance should be primarily a state responsibility. CMS should set general boundaries within which states can operate their programs. CMS should build the superstructure on which states build their programs. There is a good foundation they could focus with more direct expectations. I'd like to see them go from technical assistance to setting forth expectations."

Mr. Williams says he thinks it is reasonable for CMS to expect states to put a quality assurance plan in their waiver application and renewals and to report on the progress they make toward implementing that plan.

"GAO is correct that CMS has not required the states to report what they are doing about quality," he says. "The report also is on target that there has been a lot of inconsistency from region to region. We've told CMS that it can't work if they don't have a common regional structure. I think the states and the central office are on the same page and it's the regions that need to change."

Mr. Williams says that a National Association of State Medicaid Directors quality assurance technical advisory group has polled states on

criteria for evaluating progress and heard that the highest priorities were quality-of-life issues. However, they were unable to come up with a way to compare quality-of-life data across states and so see a need to drop back to health-and-safety issues.

Taking quality more seriously

Former Oregon official Roger Auerbach, who now consults with The Lewin Group, says the GAO report signals a commitment by the agency to take quality assurance in waiver programs more seriously than it has in the past.

He says that while the GAO's recommendations were reasonable, the tone of the report saying that CMS essentially has not been doing anything was not helpful. And, he says, state responses have been substantial since the late 1990s.

Minnesota Medicaid director Mary Kennedy says she found the GAO report "not quite on target," while the CMS response struck her as being quite good. "I don't think we want to replicate a nursing home type of certification," she says.

She reports that Minnesota has case managers for all beneficiaries with HCBS waivers and that the case managers must develop plans that address their clients' needs and wishes.

"We hope to improve linking consumer satisfaction data with data on their health needs to be sure those needs are all being addressed," Ms. Kennedy says.

[Contact Ms. Kennedy at (651) 297-7515; Mr. Auerbach at (503) 224-2596; Mr. Williams at (801) 538-6021; Mr. Mollica at (207) 874-6524; Mr. Milligan at 703) 269-5627; Mr. Verdier at (202) 484-4520; and Ms. Black at (360) 725-2311.] ■

Fiscal Fitness

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After All: Managed Care Has Made Things Better, was conducted by Vernon Smith, principal, and Linda Hamacher, senior consultant, of Health Management Associates in Lansing, MI.

Ms. Murray says it should "remind policymakers that going back to fee for service does not make sense fiscally or from a quality perspective. Managed care has improved the lives of Medicaid beneficiaries around the country."

Good for future improvements

Mr. Smith and Ms. Hamacher say in their report that not only has managed care made things better, it offers a structure to make further improvements. "The evidence shows that the traditional Medicaid fee-for-service system of the past failed to assure access to care for the most vulnerable of our citizens; failed to engage beneficiaries and providers in any meaningful dialogue or education; failed to monitor and measure the quality of care beneficiaries received; and failed to contain Medicaid costs, for the second largest program item in most state budgets," they wrote.

"Managed care offers guaranteed access to primary and specialty care, disease and care management, and coordination of services. Managed care includes monitoring, measuring, and improving the quality of care beneficiaries receive; avenues for provider relations; beneficiary and provider education; and communication. Managed care is containing costs through predictable rates, economies of scale, increased market leverage, and better integration of care. From virtually every angle, things are better now," they point out.

In fact, the two say, things are so much better now that "going back should be unthinkable." Still, no one would claim that the current system is perfect, or that improvements do not need to be made, according to Mr. Smith and Ms. Hamacher. But it is moving in the right direction.

Medicaid card, 'hunting license'?

In terms of access, they say, in 1990, when most Medicaid beneficiaries were in fee-for-service programs, their Medicaid card was in reality a "hunting license," a license to hunt for a provider who would take a Medicaid patient with the program's low payment rates. It was a hunt that often was difficult, if not impossible; because in many areas, there were not enough providers willing to accept Medicaid's payment rates.

Mr. Smith and Ms. Hamacher say the evidence shows that traditional Medicaid fee for service failed to assure access to care for the most vulnerable citizens; failed to monitor, measure, and improve the quality of care beneficiaries received; and failed to contain Medicaid costs.

"There is now enough experience with managed care to show progress where it counts," they write, "access, quality, and cost savings. States have found that managed care offers a prudent purchasing system with greater accountability and an infrastructure that supports continued improvement."

The researchers say that one of the most strongly held American values is freedom of choice. Thus, they say, it is ironic that until 1997, states had to get a waiver of freedom of choice to implement managed care. Now states can get a waiver or satisfy the same issues through the Medicaid state plan amendment process.

Whichever way a state chooses, Medicaid must assure choice of a

health plan and, within each plan, must assure choice that is better than that which is available outside of the plan.

"Choice is better within the health plan for several significant reasons: The choices guarantee access and availability; the choices guarantee a 'medical home;' the choices are among credentialed providers; [and] the choices are within a system that measures quality and is designed to assure top-notch performance," the two say. "In other words, managed care guarantees choice among alternatives that are not even available in fee for service. Within a health plan, there is freedom to choose among better alternatives."

Problems with Medicaid fee for service cited by Mr. Smith and Ms. Hamacher include:

1. Low provider participation because many physicians are not willing to accept Medicaid patients in the fee-for-service system.
2. Lack of a medical home, where patients know which provider is uniquely theirs, and providers know which patients are uniquely theirs. Patients who don't have a medical home are less likely to have consistent, continuous care; less likely to know where to go when care is needed; less likely to seek care when it is needed; less likely to go to the doctor or clinic instead of the emergency department (ED) for nonemergency care, and less likely to seek preventive or wellness visits.
3. EDs can become community medical homes for those with no other place to go, resulting in overly expensive, often unnecessary, sometimes duplicative care and services.
4. Fee for service is most unkind to the sickest, with almost two-thirds of adult Medicaid beneficiaries having a chronic or disabling condition, with nearly half of those with multiple conditions. Continuity of care is not possible in a system characterized by hit-or-miss treatment for ongoing medical conditions.

Mr. Smith and Ms. Hamacher say that by contrast, those who are enrolled in Medicaid managed care plans are "no longer relegated to ricocheting through the system like a pinball, but instead have a designated primary care physician. The days of blindly seeking medical attention are gone. Networks are monitored for capacity and the specialty, ancillary, and tertiary needs of beneficiaries.

"With a primary care physician, Medicaid beneficiaries have access to prenatal care, disease/care management for complicated cases, preventive care such as cancer screening, education about their health and the delivery system, and some continuity in treatment of chronic illnesses. Further, they are granted some degree of dignity not always possible in fee for service," they add.

Sharing best practices

Further, they say, managed care plans share best practices and continue to improve care delivery and use of services.

"In fee for service, measurement of quality is inherently difficult," Mr. Smith and Ms. Hamacher say. "By its nature, there is no structure or organization within which to measure quality or to know if it is improving or not. Fee for service produces a lot of data based on claims that are paid, but those data are not ideal for assessing quality. As a result, there are scant studies about fee-for-service quality. On the other hand, the number of studies on managed care quality has increased dramatically in the past decade, reflecting the availability of reliable quality data, the importance of managed care in the health care system, and increasing interest on the part of researchers and funding agencies." In fact, they assert, managed care's greatest success could be quality management, monitoring, and improvement.

Managed care holds costs down

Looking at state costs, Mr. Smith and Ms. Hamacher say that under fee for service, costs are unpredictable, with states bearing financial risk and using limited resources to try to control the growth of Medicaid costs.

What's worse, they say, the nature of fee for service makes it more difficult to control costs due to the inherent incentives to provide more services so more services can be billed. This can result in excessive payments, overutilization, upcoding, unbundling of services, billing errors, and fraudulent billing. In contrast, managed care is designed from the beginning to be efficient, to incorporate policies, procedures, and incentives that encourage appropriate and cost-effective care.

With a capitated reimbursement method, Mr. Smith and Ms. Hamacher point out, managed care also offers budget certainty because the health plans accept the financial risk. States use rate-setting methodologies that guarantee that Medicaid's costs are less under managed care, whether the rates are set administratively or competitively bid.

With prescription drug costs one of the principal drivers of higher Medicaid costs, they say that recent studies document superior performance of managed care compared to fee for service in controlling drug costs.

In a direct comparison of Medicaid pharmacy costs and usage between the fee-for-service and

capitated settings, managed care had better performance in terms of drug prices, drug mix, utilization review, and per-member per-month costs. Managed care organizations paid lower dispensing fees to pharmacies, experienced a 9% greater generic drug mix, and had a 15% to 20% lower utilization rate.

The overall result, they say, was a 10% to 15% lower per-member per-month cost than fee for service, even after accounting for the substantially higher level of manufacturers' rebates under fee for service.

Intense look at managed care

Mr. Smith and Ms. Hamacher say the current fiscal crisis in almost every state "presents an opportunity for Medicaid to look more intensively toward managed care.

"Managed care has shown it can deliver on greater value and better performance, and can provide excellent care for the special needs of the Medicaid population. Managed care may not yet be perfect, but it is far better than old-fashioned unfettered fee for service, and it provides the foundation for an even better system in the future," they add.

Ms. Murray says that because the report lends itself more to state-level advocacy rather than federal, it will be sent to state Medicaid directors, governors, and legislatures in those states where concerns exist. She says the report was presented at the AHCAHP conference in May and received positive feedback from those in attendance.

[Contact Ms. Murray at (202) 331-4601 and Mr. Smith and Ms. Hamacher at (517) 482-9236. To download the report, go to the AHCAHP web site at http://www.ahcahp.org.] ■

Olmstead response: Make interdepartmental collaboration a priority in your state

Imagine if your family car came in separate parts so that you had to decide which parts were needed, find where you could buy them, and then assemble them yourself. With no overall design for the car and no quality management to make sure the parts fit and determine how well the car is working, what kind of a vehicle do you think you'd have and how would you determine how cost-effective it was?

That analogy impressed a number of people in Maine as they developed their state's response to the U.S. Supreme Court decision in the *Olmstead* case involving state efforts to provide services to the disabled in a coordinated, least-restrictive environment.

A report by Eileen Griffin, a research associate at the Institute for Health Policy at the Edmund S. Muskie School of Public Service of the University of Southern Maine in Portland, focuses on efforts to marry the state's vision of an *Olmstead* response for coordination and consistency across departments with a sustainable, collaborative governance structure that will incorporate the vision into the workings of Maine's state agencies.

"While the delivery of human services is considerably more complex than car manufacture," Ms. Griffin says, "comparing the assembly of an automobile to coordinating the interdepartmental delivery and management of human services helps to illustrate the need for investing in collaboration. An automobile manufacturer sees bringing the parts of a car together and assembling them into an automobile as part of the series of steps required to produce a car. . . . In contrast, the 'assembly' of the disparate services provided by the state into a comprehensive human services system is seen as either an unnecessary step or something that should happen automatically, without additional resources.

"Interdepartmental coordination and collaboration might be a stated goal, but often departments are not given or do not make available the necessary resources to make it happen. As a result, the 'specialization' within individual departments and bureaus results in fragmentation. For a state, the cost of not collaborating means an inefficient use of resources and ineffective services. From the consumer perspective, lack of coordination means frustration, wasted time, and can sometimes lead to more dire medical consequences such as institutionalization or incarceration, poor health, or death," she continues.

Cross-system governance

Ms. Griffin notes that nothing in the Supreme Court's *Olmstead* decision specifically tells states that compliance with the Americans with Disability Act requires cross-system governance. "Yet," she says, "the complexity of ensuring compliance with *Olmstead* suggests the need for joint action across multiple components of state government." And she identifies three aspects of the Americans with Disabilities Act and the *Olmstead* decision that certainly suggest that interdepartmental collaboration is prudent, even if not required.

First, the prohibition against discrimination based on disability suggests that people with the same needs for services should not be denied services based on the type of disability they have. For example, a

person with traumatic brain injury and someone with mental retardation might both have a similar need for supportive housing. A fragmentary, rather than comprehensive, approach to meeting needs may open a state to what Ms. Griffin describes as unfortunate and divisive battles between different population groups (and across agencies).

Second, under *Olmstead*, the so-called fundamental alteration defense allows states to defend against a request for services if they can show that honoring the request would involve a harmful reduction in services to other people with disabilities who need institutional care and would lose services as a result. For a fair allocation of resources, Ms. Griffin says, states have an interest in developing standards for defining and measuring the impact of resource allocations across broad population groups.

Finally, the Americans with Disabilities Act does not attempt to set a standard of care for services a state has to offer. It prohibits states from creating barriers to integration, but does not hold states responsible for eliminating barriers they did not create.

Saw need for collaboration

As a working group set out to develop Maine's response to the *Olmstead* decision, it found that responsibility for serving people with disabilities was divided across multiple agencies and departments. In fact, several agencies had been created with the core mission of serving those with disabilities, while other agencies had more general missions but still have responsibilities that affect the services, and a third group of agencies had missions that only indirectly affect those people with disabilities, although in very meaningful ways.

"While the division of labor across agencies can be explained by the need for specialization, the needs of the people served do not fall nearly within the jurisdiction of just one agency," Ms. Griffin wrote. "Findings from focus groups, case studies, and interviews confirm that there are breakdowns in the collaboration between various departments, programs, and services when needs cross agency boundaries."

Five potential breakdowns identified by Ms. Griffin are:

1. lack of access to information;
2. no comprehensive planning;
3. conflicting regulations;
4. cross-disciplinary conflicts;
5. fragmented services.

Having studied the problem and identified concerns, the work group recommended that the state's disparate programs and services be brought together into a coherent, comprehensive system, with the state government integrating information, access, and services, as well as the infrastructure for supporting and monitoring the success of the effort.

Features identified as important to implementation of the recommendation include maintaining an interdepartmental focus; maintaining a cross-disability and cross-age focus; involving consumers; reaching local and regional providers with integrated information and referral, access, and delivery of services; providing sufficient resources for investing in improved services, the state staff necessary for developing coordinated policy and tools, funds for developing the capacity to integrate data, training regional and local staff and providers, and sustaining and improving coordinated tools and functions; dedicated staff for collaboration; authority to bring about change in policies and practices; commitment and leadership in both the executive and legislative branches of state government; and a formal mission established in law so the initiative can survive political shifts.

How to make the program work

Ms. Griffin says that the way to sustain interdepartmental collaboration is to recognize and accept the need for investing in collaboration, charge interdepartmental cabinet with addressing needs of people with disabilities, establish a dedicated staff position in the governor's office responsible for serving as liaison to cross-system collaboration, partner with legislative committees to foster cross-system coordination, designate a consortium of consumer advisors, cultivate an assembly of cross-disability consumer advocates, establish staff positions within departments dedicated to interdepartmental collaborative efforts, develop interdepartmental standards for community integration, and invest in integrating information systems. She tells *State Health Watch* that the first seven recommendations are interrelated out and it is hard to separate them and set priorities.

In conversations with people in other states, Ms. Griffin says, she has found many who agree that this sort of process is necessary to bring about collaboration.

"People in Maine and many other states have worked at collaboration but it hasn't been a priority," she says. "Many people are seeing that collaboration is needed so there is a comprehensive approach to service delivery, and it's important that we change the way we think about these issues."

Asked about the *Olmstead* committee's work and collaboration, Disability Rights Center of Maine staff member Helen Bailey expressed frustration that the group had produced recommendations rather than

a full-fledged plan. She says that in meetings she attended, agency representatives said they could not commit their agencies to anything and "every time we started talking seriously about collaboration, the agencies became very resistant. They saw our requests as increasing their liability and increasing their accountability. I don't think all this work will go anywhere. The end result is going to be that on their own, agencies will initiate something — and the consumers will get screwed."

Ms. Bailey says that while some state agencies may be collaborating with each other, they are not collaborating with consumers. She says that consumers "dropped off the committee like flies" so that it is now almost all state employees and people from the Muskie School.

The consumer's perspective

She questions whether agencies truly understand the consumer perspective, noting that clients may have a supportive relationship with one agency and an adversarial relationship with another.

"I don't think that the states that talk about collaboration to meet the needs of clients understand the deterrence to getting treatment that comes about as a result of sharing information," Ms. Bailey says.

"Agencies tend to presume motives that aren't good when clients don't want to share information. They don't appreciate how much people fear that they won't get good care. They don't understand, for instance, that consumers fear that a general practitioner physician will attribute everything to mental health problems if the consumer allows information about his or her mental health treatments to be shared with the doctor. It comes down to client choice. The less you honor that, the greater the risk of creating a deterrence to service. Why should someone who is subsidized by the state have less of a right to privacy?" she asks.

From the perspective of someone in state government in Maine, Bureau of Elder and Adult Services director Chris Gianopoulos in the Department of Human Services sees the potential for a lot of good to come out of Ms. Griffin's study and recommendations.

"I think the report was terrific," she tells *State Health Watch*. "This may be the first time that anyone was able to capture in one place all the complexities involved in attempting to deliver services to and meet the needs of people with disabilities."

Ms. Gianopoulos says the report is particularly important because of an executive order from the state's governor that the two major human service agencies essentially merge effective next July 1 to make it easier for people to access services. A working group is developing a plan this fall for presentation to the Maine legislature Jan. 1, 2004.

Meanwhile, the work group developing the state's road map to compliance with *Olmstead* has completed its public comment process and will be submitting its work product to agencies and the legislature. Ms. Gianopoulos says the collaboration report will help inform the work of both the *Olmstead* group and the agency merger group.

In many ways, she says, the road map and the collaboration paper are providing a rationale for the merger of the state agencies.

Are there things that will stand in the way of effective collaboration? One concern identified by Ms. Gianopoulos is the nature of the categorical funding that many agencies rely on that can create boundaries and the proverbial cracks through which some people may fall.

In addition, she explains, some systems, such as the one aiding those with mental retardation, have been driven by families over the years and have a strong constituent base, while others do not have such support.

Ms. Gianopoulos says it's hard to bring disparate systems together because people are fearful that they will lose the gains that they have fought long and hard to win.

"[Collaboration] is a lovely theory, but the closer you push systems together, the more the disparities come into focus," Ms. Gianopoulos points out. "People need to be aware of that so they aren't taken by surprise when issues surface. But despite all the problems and challenges, collaboration has to happen because it is unconscionable what we put people through now to get the services they need."

[For more information, contact Ms. Gianopoulos at (207) 287-9200; Ms. Griffin at (207) 780-4813; and Ms. Bailey at (207) 626-2774.] ■

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This column features selected short items about state health care policy.

Medicaid shortfalls plague Illinois

SPRINGFIELD, IL—Gov. Rod Blagojevich's administration says it has stopped the fiscal bleeding in the government medical insurance program for poor people. But hospitals, doctors, and nursing homes that serve Medicaid recipients insist they still are feeling the pain. Dr. Russell Brown, the president of Logan Primary Care Center in Herrin, IL, said the financial squeeze on the eight doctors and four physician assistants in his clinic could end Medicaid services there. Brown said other doctors in Southern Illinois already have excluded patients covered by Medicaid. As a result, his rural clinic, which receives 20% of its business from Medicaid patients, is seeing more Medicaid recipients.

"These people are losing their ability to go to physicians," he said.

Thanks to a short-term state loan, the state and federal governments infused $1.3 billion to $1.5 billion into the system in late May. That meant a $100,000 check for Logan Primary Care. But since then, the clinic's past-due Medicaid bills have ballooned to more than $167,000, Mr. Brown said.

Mr. Blagojevich, who took office in January, has repeatedly said he would protect spending on health care — along with public safety and public schools — from the ravages of a down budget year. Andrew Kane, the deputy administrator in medical programs for the Illinois Department of Public Aid, said Blagojevich has made good on that promise by signing a budget that prevents Medicaid's deficit from expanding. That will keep payments to Medicaid providers from getting any later than they already are, he said. On average, Mr. Kane said, Medicaid bills are paid to providers 55 days after the Department of Public Aid receives them.

"We have stabilized payment cycles by equalizing the appropriation with the liability. So [Blagojevich] goes a very long way toward addressing the underfunding," he said. "It stops the bleeding."

—*Quad City Times*, Davenport, IA, July 13

Medicaid to cut dental benefits for WA adults

OLYMPIA, WA—Washington will pare back adult dental coverage for Medicaid patients next month in a bid to save $22.8 million over the next two years in part by eliminating payments for overused dental procedures. That means low-income Medicaid adults will lose coverage for crowns, back-teeth root canals, and several other dental services starting Aug. 1. Children on Medicaid are not affected. The coverage changes were prompted by the new, tighter state budget. Washington was expecting to have to pay out $88.7 million in dental coverage for Medicaid adults over two years. That budget has been cut by 26% to $65.9 million. The revised dental plan preserves coverage for preventive services such as checkups and gum-disease treatments. It also keeps insurance for partial dentures and limited replacement dentures, which initially were slated for cuts. But the state will stop covering crowns, or caps that are used on teeth that no longer can take a filling. The procedure, which costs about $300 per tooth, is among those that have been "overused" by dentists who treat Medicaid patients, said John Davis, a dentist and a consultant to the state's Medicaid Assistance Administration, which oversees the Medicaid program. Tooth bonding, which is cheaper than crowns, will still be covered.

— *Seattle Times*, July 11

Medicaid may force elderly to sell homes

FRANKFORT, KY—Many elderly residents of nursing homes will be forced to sell their houses to help pay for their care under changes state Medicaid officials plan to implement Sept. 1. And the state will no longer allow heirs a "homestead exemption" of $50,500 when it seeks to recover its costs from estates of nursing home residents who have died, says state Health Services secretary Marcia Morgan.

The state also will become much more aggressive in trying to recover its costs from estates of deceased nursing home residents, she says. Those steps are among several Ms. Morgan and state Medicaid Commissioner Mike Robinson outlined recently as part of a continuing effort to reduce a multimillion-dollar deficit in the federal-state health plan for the poor and elderly in nursing homes. The measures would save the state about $18 million in the fiscal year that began July 1 with increased savings in future years.

Kentucky currently has about 17,000 people in nursing homes. About 75% of them are covered by Medicaid. Ms. Morgan acknowledged the new steps are likely to be controversial with the public and with lawmakers. "But we have no good alternatives at this point," she said.

—*Louisville Courier-Journal*, July 10

Doctors applaud repeal of Medicaid pay cuts

LAS VEGAS—Sick, poor Nevada children should get their doctors back after state Medicaid officials rescinded recent pay cuts to pediatric specialists. The move to increase reimbursement rates came after at least 25 specialty physicians stopped taking Medicaid patients in May, forcing at least one family out of state for care.

The rates will return to approximately what they were before the state cut them, said Charles Duarte, administrator for the Nevada State Division of Health Care Financing and Policy.

The rate increases will be retroactive to May 8, when the reimbursement rates were first slashed. The money to increase rates will have to come from some other Medicaid program, although it's unclear yet which program will face cuts, Mr. Duarte said.

"It should just be a matter of days before the claims will be automatically processed at the revised rates," he said.

"Overall, doctors will be getting paid the same as they did before, but procedure to procedure, reimbursement rates will be a bit different," Mr. Duarte explained.

The rate increases will affect doctors who perform surgical or radiologic procedures on patients under age 21. Many pediatric specialists who stopped taking Medicaid patients in May say they'll start seeing new patients again under the revised rates.

Those physicians said the reductions in rates, in some instances by as much as 80%, made caring for Medicaid patients unaffordable. They also said the large reductions in payment didn't give them adequate income to pay their office overhead and remain in business.

— *Las Vegas Review-Journal,* July 15

1,800 could lose Medicaid benefits

LEXINGTON, KY—Nearly 1,800 Kentuckians are in danger of losing Medicaid services under state cost-cutting measures, according to Medicaid records through the end of June. The cuts are intended to ameliorate a $450 million Medicaid budget deficit for this fiscal year. They're based on the assumption that people affected by them would be able to afford care on their own. Those who have lost coverage under the federal-state health plan for the poor include about 216 people seeking nursing home care. But the rest, 1,566 people, are those seeking assistance in the home or community because of illness or disability. That number includes older Kentuckians, the mentally disabled, and emotionally disturbed or autistic children receiving therapy through Medicaid. Earlier this year, the state eliminated the "personal care" category of Medicaid service intended for recipients not seriously ill or disabled and not in need of intensive nursing care. Now, the state is reviewing its Medicaid recipients and applicants with an eye toward cutting some off under the new rules to keep the program running. "We have consistently said there would be consequences," state Health Services secretary Marcia Morgan said. "We very much believe we ought to cover those most in need and those most vulnerable, and there are no good choices left."

—*Lexington Herald-Leader*, July 21

Medicaid coverage for 10,000 in state is back on hold

LINCOLN, NE—Despite a federal court decision, low-income parents in Nebraska who lost Medicaid benefits during the past year because of budget-cutting decisions will not have their medical services reinstated immediately. The Nebraska Health and Human Services System (HHSS) has asked the federal court to reconsider its decision that Nebraska likely illegally ended Medicaid services for more than 10,000 Nebraskans, generally low-income working mothers. The state's request effectively delays the court's temporary injunction requiring HHSS to reinstate the cut-off Medicaid recipients. Attorneys for the plaintiffs will seek a quick dismissal of the state's petition, arguing that the likelihood for the state to get a rehearing is extremely low.

— *Lincoln Journal/Star*, July 18