Making Medicaid Work

A Practical Guide for Transforming Medicaid

SHPS®

Center for Health Transformation

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SHPS, a leading provider of health advocacy and healthcare consumerism solutions, and the Center for Health Transformation (CHT), a collaboration of leaders dedicated to creating a 21st century intelligent health system, are pleased to co-author *Making Medicaid Work: A Practical Guide for Transforming Medicaid*.

Medicaid programs provide health services and/or residential care to more than 50 million vulnerable Americans – each of whom has unique personal health needs. Medicaid pays for the prenatal care for one-third of our nation's children, the long-term care for more than 20 percent of our frail elderly citizens and provides a critical health safety net for people with disabilities. Several states are also working on parallel initiatives to cover the uninsured.

But today's Medicaid system faces a severe crisis of sustainability. A typical state has seen Medicaid costs double as a percentage of their budget since the mid-1990s with continued disproportionate growth projected. Combined federal and state expenditures totaled $320 billion in 2006 and are projected to reach $580 billion by 2016.

Medicaid both shapes, and is shaped by, the broader crisis in America's healthcare system. Incremental improvements of a broken system cannot overcome the need for fundamental structural reform. Medicaid can – and *must* – be transformed. The good news is that through thoughtful and pragmatic application of principles of healthcare consumerism, care coordination, and 21st century technology, such as electronic health records and e-prescribing, we can create a new and better Medicaid.

True transformation will occur when beneficiaries, administrators, policymakers, and the broader public are engaged in a constructive, honest and open dialogue. While this debate will not be easy, it must begin. A transformed Medicaid has the potential to positively change our nation's healthcare system, including opening the door for uninsured Americans.

Making Medicaid Work outlines a framework for creating a 21st century Medicaid system that is intelligent, saves lives and controls costs. While the thought process will continually evolve, the focus must always be: "Are people on Medicaid getting healthier?" Our hope is that this book will contribute to this thought process and stimulate a broad public dialogue. As such, SHPS and CHT welcome your feedback. We would like to salute the federal and state legislators, Medicaid administrators and vendors who work daily to make Medicaid work for the American people. We applaud your efforts and look forward to working side by side with you throughout the next phase of Medicaid's transformation.

Wishing you good health,

Rishabh Mehrotra Newt Gingrich

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SHPS
President & CEO

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Executive Summary: Making Medicaid Work

What has been missing from public discussion is a broad policy framework that brings together current initiatives and makes breakthrough transformation possible.

Making Medicaid Work: A Practical Guide for Transforming Medicaid **is a collaborative effort between SHPS and the Center for Health Transformation to analyze and discuss the profound challenges facing our nation's Medicaid system.**

In the following pages, we will take a critical and holistic look at Medicaid as it exists today, propose a framework for transforming it and recommend practical steps that individual states can implement within their programs to promote better health and social advancement for their citizens most in need.

To be clear, we do not propose to have all the answers to the Medicaid crisis, nor can we duplicate the extensive body of Medicaid research already in existence. What has been missing from public discussion, however, is a broad policy framework that brings together current initiatives and makes breakthrough transformation possible. As a nation, we have already made a commitment to provide healthcare for our citizens most in need. How then do we maximize the value and effectiveness of this program? Our purpose in writing this book is to engage the entire civic community – legislative, administrative, medical, commercial and citizenry – in an open dialogue on Medicaid, evaluate viable policy alternatives and make sensible choices.

As part of our inquiry, we conducted interviews with some of our nation's most respected and forward-thinking public health officials, including current and former Medicaid directors, state health secretaries, Centers for Medicare and Medicaid Services (CMS) administrators and the secretary of the U.S. Department of Health and Human Services, Michael Leavitt. We have embedded excerpts from these interviews throughout the book. Their first-hand accounts provide a testament to the challenges facing state Medicaid programs today as well as the potential for reform and innovation.

Before true reform can occur, however, we need to examine the nature of the Medicaid crisis and how it has escalated so rapidly. In our opening chapter, we consider three core issues facing Medicaid: unsustainable cost, climbing enrollment and poor quality. Total Medicaid spending accounts for 2.6 percent of the nation's entire gross domestic product today, including $182 billion in federal spending. It now constitutes one-fourth of all state expenditures and as much as 50 percent of new incremental spending. Medicaid enrollment has grown by 40 percent over the last five years, and it faces even more strain as baby boomers reach retirement age with epidemic levels of chronic diseases such as diabetes, asthma, heart disease and high blood pressure. Ironically, future Medicaid expenditures depend heavily on populations that are not eligible for Medicaid coverage today, but will likely be in the future.

And yet, for all the money that has been spent, the care being administered under Medicaid today is inadequate and often sub-standard. Recipients have difficulty accessing care and, when they do, it is rarely as effective as the care available to the commercial population. One study showed Medicaid lagging behind private insurance in all but seven of 48 Health Plan Employer Data and Information Set (HEDIS®) measures for healthcare effectiveness. Medicaid can fund medical procedures and prescription drugs, but it is far less clear that it is driving better health outcomes or enabling recipients to lead healthier, more independent lives. Ultimately, the Medicaid crisis is one of *value*. We are accomplishing less and spending more – and failing those we aspire to help.

Unfortunately, the existing Medicaid infrastructure harbors systemic and pernicious barriers to reform. In Chapter Two, we consider a range of factors that prevent Medicaid from functioning effectively. One barrier is its sheer complexity. Medicaid is not a standardized nationwide program, but rather a collection of 50 different state programs residing under one umbrella. Within each state, distinctive populations of Medicaid recipients exist: young, old, rural, urban – the list is as long as the unique needs associated with them. Program variability at the state level does not necessarily benefit individual recipients, who often face inconvenient services, rigid benefits and limited care choices. However, program variability does lead to fragmented population health metrics, technology silos and uncoordinated care. As a whole, Medicaid continues to primarily focus on delivery of acute healthcare: paying for medical procedures while not fully addressing preventive health, social issues and disease management of chronic diseases – things that temper the demand for acute healthcare in the first place. Medicaid programs are poorly positioned to measure, manage and mitigate the health and financial risks of recipients – a primary requirement for the effective operation of any multi-billion dollar health plan.

Perhaps the biggest challenge to Medicaid reform is the flow of money from federal to state government and, ultimately, to a local health provider serving an individual recipient. Federal matching funds were originally designed to encourage state participation in Medicaid, but their purpose has been distorted over time. At the state level, these funds encourage program expansion, not efficiency. Providers, in turn, maximize revenue through the volume of reimbursable procedures. Recipients may receive little support to manage a chronic disease, but can count on coverage for emergency room

visits or inpatient admissions to treat the resulting complications. Medicaid has evolved into an economic stimulus package that supports tens of thousands of jobs. Attempts to reform it rapidly devolve into an argument over economic impact and job preservation, rather than the health and well-being of recipients. The result is a distorted healthcare delivery model that favors expensive acute and institutional care at the expense of alternate social investments that would promote prevention, encourage personal independence and address the underlying social conditions that drive high healthcare utilization.

While the Medicaid system in is in peril, SHPS and CHT have found many reasons to be optimistic about its future, provided we transform now. In Chapter Three, we evaluate what the ideal Medicaid program would look like if designed from scratch. By reviewing best practices from the private sector to determine which could be applied to Medicaid, we concluded that the ideal Medicaid program will differ in its details from state-to-state, much as they do today. However, it will conform to four critical principles.

These principles provide a backdrop for driving Medicaid transformation and are useful tools when evaluating any proposal for reform:

- **Align structure and incentives.** Medicaid's structure and financial incentives must align

with its primary goal: improving the overall health and quality of life for recipients, at a sustainable cost, through the effective use of scarce resources. Although the Deficit Reduction Act (DRA) offers some flexibility, states should be rewarded, not penalized, for reform. Providers should be rewarded for achieving better health outcomes, not generating high volumes of procedures. Recipients should receive targeted plan designs with the opportunity to improve personal health.

- **Promote social advancement.** Program design and services should encourage individuals to take on as much personal responsibility as they can handle, without punishing those who cannot. The loss of Medicaid coverage should never be a barrier for a recipient seeking a higher-wage job. Savings achieved through better management of personal health should be reinvested to address the underlying social conditions that drive poor health and increase the demand for Medicaid services.
- **Manage health and financial risks.** Medicaid administrators must have a comprehensive understanding of their state's health and financial risks and the ability to continuously monitor the health status of the entire covered population. Without this data, states are essentially operating multi-billion health insurance programs in a vacuum.
- **Provide integrated delivery.** Rather than reimbursing a medical procedure, Medicaid programs need to focus on the whole person by simultaneously addressing all the factors that prevent effective self-care and personal health. To accomplish this, these programs need advanced technology, personal health records, integrated care coordination, new regulation and a service delivery model that permits highly-personalized services on a scalable basis.

In Chapter Four, we apply these four principles through a series of practical action steps that states can take to transform their Medicaid program in a structured, holistic manner. We move beyond strategy and program design to look at ways to fundamentally redesign service delivery to recipients. By following this framework, states can create a Medicaid program that meets the unique needs of their population. The ideal Medicaid program is both highly responsive to individual needs and highly cost-effective, because it not only provides treatment – it also targets the underlying risk drivers that lead to poor health and higher medical utilization.

While further transformation is needed at the federal level, states must be prepared to provide additional leadership and initiative from the outset. Our research suggests that, while still in the early stages, many states are already proposing and adopting highly-innovative strategies. We suggest new procurement processes with request for proposals (RFPs) that support program integration, and a program management office to support successful implementation. When these strategies are combined with thoughtful implementation, the impact can be considerable.

SHPS and CHT would like to thank the many individuals on Medicaid's frontlines. Your commitment and passion for improving the health of our most disadvantaged citizens is commendable and inspirational. We hope this book will serve as a starting point for the transformation of Medicaid, and we look forward to working with federal and state administrators in designing practical strategies for *Making Medicaid Work.*

INSIGHT

Secretary Michael Leavitt provides an overarching federal-state view of Medicaid today

First off, let me provide a bit of perspective. When I was elected governor of Utah in 1992, Medicaid was a single-digit percentage of our state budget. At the time of my departure 11 years later, it was consistent with other states – well over 20 percent. This level of spending means that Medicaid crowds out other important social programs.

A common misperception is that Medicaid is one program. Above and beyond state-to-state variations, it is one part of the statute stretched over several different populations. There's the neediest in our country, which has been the traditional Medicaid population; then, there's pregnant women and children needing protection; and finally, there's the disabled and long-term care recipients. Of course, there are always those that just need help buying insurance.

"Demographics is destiny," as they say. When you consider the long-term care aspect, Medicaid will soon swamp us financially. It will affect U.S. competitiveness by diminishing our fiscal capacity to educate, build infrastructure and protect our citizens. On top of it all, a one-size-fits-all approach to Medicaid is not good management; it's an inefficient system that's harmful to poor people and minorities.

On fraud and abuse

Because of Medicaid's joint funding, federal oversight has always been an issue. Overall, the amount of fraud in Medicaid and Medicare is shameful. While it's a difficult problem to tackle, states need to emphasize it more and ramp up enforcement. It also requires better tracking technology and greater incentives for everyone involved. I think that oversight is better now than in the past, because we have begun to crack down on financing schemes. While there are still abuses, they have begun to diminish due to such federal pressure. Further reforms, such as the recent Deficit Reduction Act (DRA), can improve things even more.

As I travel across the country speaking to federal agents investigating fraud, some argue that having the private sector involved – where they have a financial interest in halting irregularities – results in less fraud than a government program where people dip into a pot almost at will. While the jury's still out on that, there's every indication that the private sector can help alleviate fraud and abuse.

On reform and the uninsured

If I could make one major change, it would be dividing Medicaid into at least three programs. Granted, you don't need three separate mechanisms; however, I would treat all of these populations differently with separate eligibility rules and benefit structures that fit their unique needs. You must give states the same tools any other benefit manager has to create the right incentives and optimize the value for those they serve.

If I could change another aspect of Medicaid, it would be the disproportionate share hospital (DSH) program. The way our nation deals with healthcare for its uninsured deeply troubles me. We have a two-tiered system across the country when it comes to the uninsured. The bottom line is that we should use the uncompensated care

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Michael Leavitt
U.S.

Secretary, Department of Health and Human Services

"When it comes to actual healthcare delivery, a medical home and an electronic medical record is a dynamic combination. Medicaid can be a proactive force in reforming healthcare overall – and that point is often overlooked in public policy discussions."

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money that supplements Medicaid to help people buy insurance. They would have better care; their healthcare would be provided much more efficiently; and greater preventive measures would help keep a lot of people from becoming sick.

How can states help their citizens buy insurance? First, develop alternatives outside of Medicaid. Long-term care and the uninsured will be Medicaid's biggest cost drivers. As I mentioned earlier, demographic trends will overwhelm Medicaid spending if it becomes the standard bearer of long-term care. For the uninsured, states need the flexibility to help make health insurance affordable. Right now, Medicaid is the default coverage for those that can't otherwise get into an insurance pool.

There are several alternatives to the pooling problem outside of Medicaid. If you're going to use public money, you're better off supporting individuals rather than supporting institutions. Supporting 1,000 people with a basic, affordable healthcare plan makes more sense from a public policy standpoint than giving a limited number of individuals a "luxury" healthcare plan via Medicaid. Simply put, coverage for one thousand versus coverage for one hundred results in a public good.

When it comes to actual healthcare delivery, a medical home and an electronic medical record is a dynamic combination. Medicaid can be a proactive force in reforming healthcare overall – and that point is often overlooked in public policy discussions. The federal government is in the early stages of working with states to increase transparency, using Medicaid as the driving vehicle. And with the DRA, the door has opened up for opportunity accounts – or the equivalent of health savings accounts – where states can leverage Medicaid funds to provide incentives for recipients to not only to stay healthy, but also make wise healthcare decisions.

On the ideal Medicaid program

If I were charged with creating the ideal Medicaid program, I would codify the program's philosophy from the outset. Citizens have a personal responsibility to do everything possible to get health insurance through our own means before turning to the government. Yet for the poor, elderly, disabled, low income pregnant women, families with children and children needing protection, I would make the statement that, as governor, the state offers a program to help. Outside of these at-risk groups, the state will help you obtain health coverage – and ensure that it's affordable.

Then, I would divide Medicaid into three programs with differing eligibility criteria; use private carriers to administer these programs; provide recipients with more choices; offer incentives for staying healthy; impose a financial consequence for every action – whether good or bad; and, finally, emphasize prevention. We've got to begin helping people – and that doesn't necessarily mean sending money to institutions. Money needs to follow the person.

On Medicaid's future outlook

Looking toward the not-so-distant-future, I foresee a tsunami-like problem coming at us. It's the retirement of the "Baby Boomer" generation. The U.S. must find a different approach to caring for our frail elderly outside of Medicaid. Otherwise, we'll stagger under an ever-increasing financial burden.

Chapter 1: Medicaid– A Profound State of Crisis

Medicaid is part of a larger healthcare system that isn't working very well. So it's hard to fix Medicaid when the mainstream healthcare system surrounding it is struggling to adapt to today's rapidly changing environment as well.

– Leslie Clement
Idaho

Division of Medicaid Administrator, Department of Health and Welfare

Medicaid is a fundamental expression of our society's compassion for those in need, as well as a pragmatic exercise in the management of public health.

In simplest terms, Medicaid, a program funded and administered jointly by federal and state government, pays for the healthcare of our most disadvantaged citizens – the disabled, the needy and the frail elderly. Historically, despite its flaws, Medicaid has performed an almost heroic function. It is one of the most important pillars in the American health system as it exists today.

Yet the current Medicaid system is in a state of profound crisis. This crisis arises from three core challenges:

Affordability: The cost of Medicaid is no longer sustainable. The National Governors Association reports Medicaid is now the single largest line item in most state budgets – even surpassing public education, if federal funding is included. In 1985, the average share of state budgets set aside for Medicaid was 8 percent; in 2003, it was 22 percent. Total state and federal spending on Medicaid now accounts for 2.6 percent of the nation's *entire gross domestic product*.

- By 2009, 21 states will spend more than one-half of every new tax dollar on Medicaid; 10 of these states will spend 75 percent or more of incremental revenues on Medicaid.
- The Congressional Budget Office (CBO) projects an 8 percent annual growth rate between 2006 and 2016. That translates into $182 billion in federal Medicaid spending in 2005 and $413 billion by 2016 – and doesn't include states' share of the funding requirement.
- The Deloitte Center for Health Solutions estimates that Medicaid will cost taxpayers more than $5 trillion over the next decade.

Socio-Demographic Trends: A rapidly aging U.S. population, backfilled with a younger generation of working poor, will drive higher Medicaid utilization and spending in the years to come. Equally worrisome are projected increases in the cost of coverage for individuals with disabilities, a phenomena driven by multiple overlapping risk factors such as mental health, aging, chronic disease, increased lifespan and shortages of community health resources to support non-institutional solutions. In 1968, Medicaid paid for one-fourth of all long-term care spending in the U.S. By 2004, it paid for almost half of all long-term care spending. Seniors and persons with disabilities make up just 30 percent of recipients, but consume 70 percent of all Medicaid spending. Roughly 42 percent of all Medicaid expenditures are for dual-eligibles, recipients also enrolled in Medicare. As the vanguard of the baby boomers reach retirement age in 2011, we can expect dramatic increases in need, barring new and more effective approaches to managing personal health and more cost-effective care solutions for the frail elderly.

At the other end of the spectrum, Medicaid covers 37 percent of all U.S. births today and provides a lifeline to the working poor. Research by SHPS, as well as other entities, consistently shows that poverty and chronic diseases are closely linked. Current estimates suggest that 61 percent of adults and 31 percent of children on Medicaid have at least one chronic condition or disability. Nearly half of the adults in that group have multiple chronic conditions.

Diabetes, asthma, heart disease and high blood pressure – all chronic diseases that can lead to costly hospitalization and disability when poorly managed – are rapidly becoming epidemics across the entire U.S. population, but particularly

among the nation's disadvantaged. In addition, untreated depression and schizophrenia remain major challenges for Medicaid populations.

The great irony is that a large portion of future Medicaid costs will be driven by the health status of populations not covered by Medicaid today. Clearly, Medicaid needs to be viewed in the context of a broader overall health policy.

Effectiveness: We are not spending our money wisely, to the detriment of recipients and society as a whole. Today, Medicaid primarily pays for costly acute and long-term care, while doing little to manage the poor lifestyle choices, chronic diseases, mental illness and social conditions that drive demand for these types of care.

When Medicaid recipients receive care, it is often sub-standard. Out of 48 HEDIS measures for effectiveness of care, Medicaid lags behind private insurance in all but seven measures. Only 50 percent of doctors will accept a new Medicaid patient – compared to more than 70 percent for Medicare and privately insured patients. Compliance with evidence-based treatment for a typical Medicaid patient is estimated at 54.9 percent, slightly below the already-poor average of 55.2 percent for private managed care patients and 57 percent for Medicare patients. Estimates of improper claims and fraud are hard to verify, but suggest that between 3 percent and 10 percent of all Medicaid claims filed are irregular in some way. While Medicaid can fund procedures and prescription drugs, it is not clear that it is driving better health outcomes or enabling the social advancement that results when individuals are able to lead healthier and more independent lives.

Historically, the expedient remedy for rising costs within Medicaid has been a series of incremental, or procedural, steps:

- Shift some of the cost burden – particularly costs associated with long-term care for the frail elderly – to Medicare or other government programs;
- Reimburse providers at less-competitive rates; and
- Tighten eligibility requirements.

However, procedural steps will no longer work. Our belief is that core and systemic change is required. Today's Medicaid system is fundamentally broken. Vertical links between the federal government, state governments and municipalities – and horizontal relationships between recipients, providers and community resources – have created holes in one of our society's most important social safety nets. Moreover, the dual eligibility of Medicaid and Medicare leads to inconsistent care practices and duplicative processes without transparency to the recipient.

States walk a thinning tightrope in balancing coverage, costs and benefits while adapting to external factors and legislative constraints as best they can. Recipients face barriers to access and sub-standard care vis-à-vis privately insured populations. In short, Medicaid does not provide "bang for its buck."

Mitch Roob
Indiana

Secretary, Family and Social Services Administration

"We're doing a good job of providing acute care, but we could do a better job of prevention and lifestyle change."

INSIGHT

Personal responsibility and the role of managed care and consumerism in Medicaid

The role of managed care and consumerism, as it relates to personal responsibility in a Medicaid program, creates an interesting dichotomy. The spirit of managed care – as it was originally created – was not a cost containment mechanism. It was a health improvement mechanism that included the spirit of consumerism. It has evolved to become a word for decreasing utilization. It was never intended to be that. So as a utilization manager, managed care has failed. I ran a relatively small HMO at a hospital and we were able to create good health outcomes for patient populations, but it involved a lot of health coaching.

We're doing a good job of providing acute care, but we could do a better job of prevention and lifestyle change. If we, and I'm speaking collectively for the healthcare system, don't get better it will be harder in the future to sustain the care levels we provide today. Indiana is spending about $4.6 billion on Medicaid, and we're not necessarily using that money in a systemic way to create healthier Hoosiers. We don't engage them in taking personal responsibility for their own wellness. And, ultimately, we have to change that. At the end of the day, we're so focused on meeting our near-term budget numbers that we don't focus as much as we should on making our Medicaid recipients healthier.

I think the problem with consumerism is that there's not always going to be a social service component. Consumerism expects the individual to be able to do something on his or her own. For an able-bodied population, that's probably correct. I think for other populations inherent to Medicaid that may not be the case. For example, I'm not so sure consumerism works for very low-income pregnant women. We tried a brand of consumerism with low-income pregnant women and gave them incentives to show up for their appointments, but we concluded that the women who were getting the incentives were the women who were going to come anyway.

On the other hand, we've verified stories around our welfare reform regarding folks who appreciated the fact that Indiana motivated them to get a job and become more responsible. For transforming Medicaid, the most beneficial thing we can do is engage honest, personable responsibility inside the program. Indiana has a plan for non-entitled personnel that uses a medical savings account. The recipient pays a small portion and we use consumerism concepts to help change behavior. If we can prove consumerism works in this environment, we'll transition an entitled population into the program.

I think it's naïve to believe that either consumerism or managed care is the silver bullet. You've got to have a number of different choices in your arsenal, and you should design a program based on the population that uses components of both to address a particular issue. In my own mind, consumerism and managed care are not mutually exclusive.

Chapter 2: Today's Medicaid Environment – And How We Got Here

By definition, Medicaid covers many individuals with disabilities. Medicaid covers individuals in long-term care, which typically are not covered by the commercial insurance market. Many of Medicaid's tools and concepts may be more or less applicable depending on the population – and depending on how you choose to apply those tools and concepts.

– Mark D. Birdwhistell
Kentucky

Secretary, Cabinet for Health and Family Services

The current Medicaid environment is changing more rapidly than ever before. States are struggling to provide quality healthcare to their populations most in need, while operating within restrictive budgetary and legislative constraints.

While most Americans are familiar with the term "Medicaid," few understand the intricacies of the program. There is a gulf of knowledge between the legislative and administrative experts striving to keep the current Medicaid system running and the ordinary taxpayer footing the bill.

To be clear, the legalities and social research surrounding Medicaid are enormous–and our goal is not to recreate it. Yet there are a number of important facts about Medicaid today, and the events leading to its current state of crisis, that directly impact policy planning in the future.

Eight Issues Fueling Today's Medicaid Crisis

1. Program Variations

From its inception in 1965 under Title XIX of the Social Security Act, Medicaid was designed to empower individual states to administer their own programs on a voluntary basis. Federal legislators created the Centers for Medicare and Medicaid Services (CMS) to monitor state programs and ensure their compliance with federal requirements for service delivery, quality, funding and inclusion of certain eligibility groups. However, states were given the flexibility to design and modify most aspects of their Medicaid program based upon the unique needs of their population–as well as local political climates.

Over time, this latitude has created a patchwork of different Medicaid programs across the U.S., each with its own name, eligibility requirements, covered services and reimbursement schedules. For example, Rhode Island (Right Care) covers pregnant women at 250 percent or less of the federal poverty level (FPL), while nine states only cover pregnant women at 133 percent or less of the FPL (the minimum eligibility level). As for prescriptions, Florida Medicaid does not require co-payments (but limits coverage to four brand name prescriptions a month); Kentucky (*KyHealth Choices*) requires a $1 co-payment per prescription; and Kansas (KMAP/HealthWave 19) requires a $3 co-payment per prescription (the maximum prescription cost-sharing amount allowed). Moreover, the operational infrastructure and technology needed to support each program are often unique.

The result: Medicaid is not a standard program; rather, it is 50 different programs under one umbrella. So while flexibility allows for innovation, state-to-state variability in program design makes reform challenging.

2. One-Size-Fits-All Approach

While every state has its own distinct Medicaid program, that variability doesn't necessarily benefit individual Medicaid recipients. Ironically, many states have limited plan and program choices and fragmented technology platforms, delivery models and health metrics. The typical Medicaid program tests for eligibility against standard criteria and covers a schedule of approved medical procedures, without consideration of individual needs, and it sometimes includes a location specific pilot program. This "traditional" healthcare approach works poorly with Medicaid populations and has spawned many of the problems states face today.

It is important to consider the extraordinary diversity within Medicaid populations. In 2006, 55 million people, nearly 20 percent of all Americans, received health coverage through Medicaid. This largely precludes a uniform approach to meeting their healthcare needs.

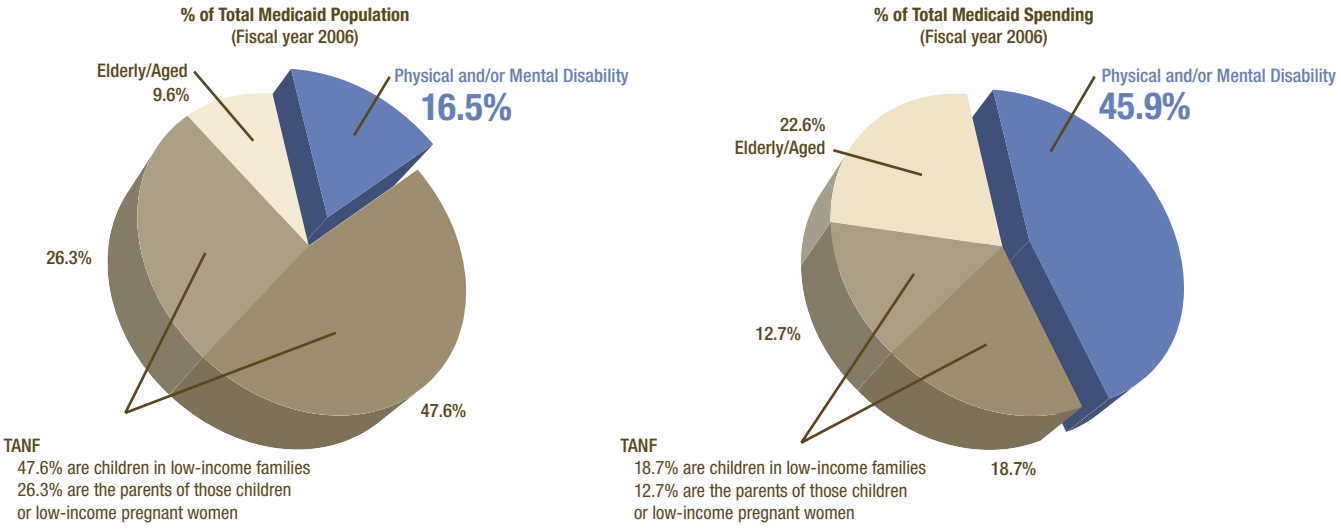
In fact, only one characteristic is common to this population: low- or limited-income status. The Congressional Budget Office (CBO) estimates that Medicaid covers at least 35 percent of all individuals with family incomes below the poverty level.

There are three key eligibility pathways to Medicaid:

- Children in low-income families or low-income pregnant women that enter through the *Temporary Assistance for Needy Families* (TANF) program;
- The physically and mentally disabled; and
- The elderly.

Figure 2.1 analyzes these segments in more detail using fiscal year 2006 data from the CBO. Despite accounting for just over one-quarter of recipients, the disabled and elderly drive more than two-thirds of Medicaid spending, largely due to the need for long-term care.

Figure 2.1: Differentiation among Medicaid Population Segments



A "one-size-fits-all" approach to Medicaid populations is unrealistic and unlikely to drive meaningful improvement. Recipients vary within a host of demographic measures–including eligibility pathway, needed services, ability to perform self-care, age, location, race and education level–so plan designs need to recognize the diversity of the various populations served. And as Figure 2.2 illustrates, just one demographic divide–rural vs. urban areas–leads to measurable differences in provider access, health behaviors and care outcomes.

These variations in demand and supply require unique programs for different Medicaid-eligible populations. For example, New York offers special needs plans (SNPs) to recipients with complex conditions, such as HIV/AIDS and severe mental illness, providing specialized services, case management and education. For elderly recipients requiring long-term care, some states offer Programs of All-Inclusive Care for the Elderly (PACE), which provide home healthcare services in lieu of institutionalization.

The result: States face the worst of all worlds–variability that does not deliver value and standardization that does not create quality or economies of scale. Recipients face a monolithic system that seems bureaucratic, impersonal and unresponsive. This helps explain why states pay so much for Medicaid, yet get such poor value.

Figure 2.2: Rural vs. Urban Effects on Medicaid

	Rural Residents	Urban Residents
Percentage Enrolled in Medicaid	14.7%	11.2%
Percentage of those Under Age 65 Reporting Medicaid as Primary Health Insurance	15.3%	11.2%
Percentage of Elderly Receiving Medicaid Benefits	10.1%	8.2%
Practicing General Pediatricians	4 per 100,000	24 per 100,000
Practicing General Internists	10 per 100,000	52 per 100,000
Inpatient Heart Attack Deaths	108.3 per 1,000 Caucasians 155.6 per 1,000 Hispanics	96.4 per 1,000 Caucasians 97.8 per 1,000 Hispanics
Inpatient Admissions for Uncontrolled Diabetes	35 per 100,000 Caucasians 176.3 per 100,000 African-Americans	13.8 per 100,000 Caucasians 76.7 per 100,000 African-Americans
Smoking Prevalence	19% of Adolescents 29% of Adults	11% of Adolescents 22.5% of Adults
Practicing Dentists	29 per 100,000	62 per 100,000
Dental Visit in the Past Year	59.8% of Caucasians 43.6% of African-Americans 47.5% of Hispanics	69.8% of Caucasians 58.7% of African-Americans 51.7% of Hispanics

3. Emerging Health and Social Issues

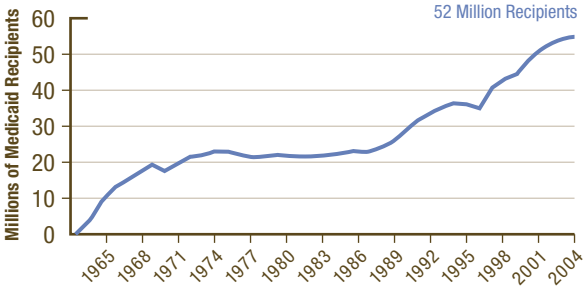
Medicaid provides health coverage to millions of America's citizens most in need that would otherwise go without. Yet as Figure 2.3 illustrates, continuous enrollment growth threatens its sustainability. To soften these demands, underlying social issues must be addressed–helping recipients take control of their health and eventually enter the mainstream healthcare system.

Culture of dependency

Some believe that Medicaid fosters a "culture of dependency"–whereby its recipients rely on the government for care and never become independent. Others feel the program is an important social safety net that helps children who are impoverished, individuals with disabilities and individuals who are elderly receive essential healthcare. The truth is likely somewhere in the middle.

For some recipients, Medicaid is a temporary helping hand during a rough patch in life. For the elderly and disabled, it's likely their only available source of much-needed care. Empowering recipients to take greater control of their healthcare decisions and spending is key to transforming Medicaid. This empowerment may help recipients exert greater decision making over their lives, as well as their healthcare.

Figure 2.3: Eligibility Expansion and its Effect on Total Medicaid Enrollment

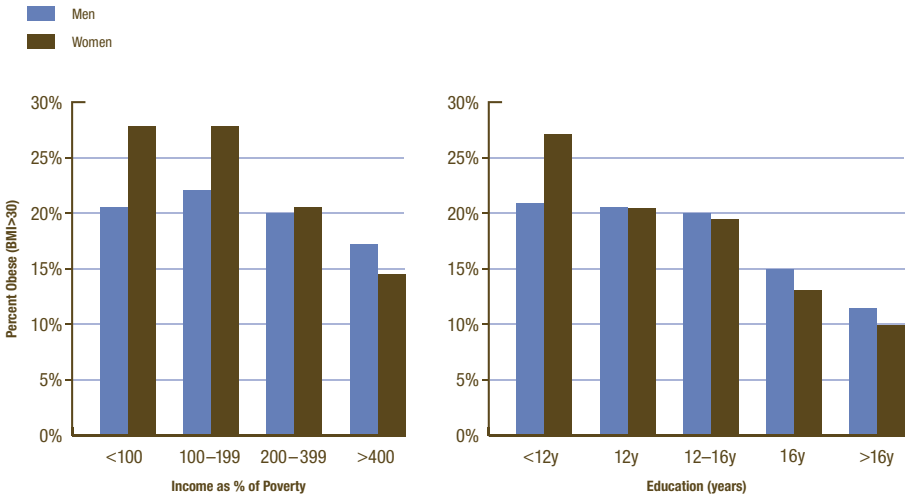


Declining health and income

Does poverty drive poor health or does poor health drive poverty? This paradox illustrates an important point; rather than merely providing coverage for healthcare needs, a transformative approach to Medicaid also addresses the underlying social factors contributing to those needs and offers incentives for healthy behaviors.

Using data from the National Health Care Survey (NCHS), Figure 2.4 shows that those with less education and lower incomes are more likely to be obese than their wealthier, more educated counterparts. Another study found that nearly 50 percent of adult recipients with chronic health conditions did not graduate high school. And since the average Medicaid recipient reads at a 5th grade level or below, low literacy hinders their ability to read and understand forms, engage in meaningful dialogue with providers and benefit from available health education materials.

Figure 2.4: Correlation between Obesity and Low Income/Education



Other studies have reached the same conclusion: *people with low education and low incomes are much more likely to have unhealthy behaviors–and face greater challenges when trying to improve them*.

The result: The cumulative effect of unhealthy habits has magnified the epidemic of chronic diseases such as diabetes and heart disease. Each year of Medicaid enrollment growth introduces new recipients with costly conditions. Lacking incentives to improve health behaviors and "pre-existing condition" clauses common in private insurance, recipients can become dependent on Medicaid coverage and never "graduate" from the system.

4. Long-Term Care Crisis

Medicaid is our nation's primary payer of long-term care services provider for the elderly. While health treatment for those over the age of 65 is otherwise reimbursed by Medicare, long-term residential and nursing care are provided by Medicaid. Although no one knows what the future holds, there are several sources of concern on the horizon for every Medicaid program.

The "Age Wave"

Beginning in 2011, baby boomers will cross the "65 and older" threshold en mass–increasing enrollment and driving higher costs via long-term care needs. Even today, more than two-thirds of all Medicaid costs are from elderly and disabled populations. By 2040, U.S. Census data projects a 250 percent increase in the number of Americans aged 85 and older, and twice the number of disabled elderly. While family and friends provide the majority of today's elderly care outside of nursing homes, the number of elderly without such support will reach 1.2 million by 2020–nearly twice as high as in 1990. As life expectancy climbs upward, Medicaid will shoulder more healthcare costs over longer periods of time.

Structural Inefficiencies

Age is only one factor driving demand for long-term care. Poor self-management of chronic disease, inadequate healthcare prior to age 65, lack of coordination between specialists, inadequate housing, lack of flexible home care alternatives and payment rules with an institutional bias are key factors driving higher utilization. If a nursing home subsequently hospitalizes a patient, the costs are then off-loaded to Medicaid. Inconsistent coverage and coordination between Medicaid and Medicare prevents either program from effectively measuring and mitigating health risks. Many of today's uninsured will be tomorrow's Medicaid recipients.

The Retirement Dilemma

Another factor driving higher Medicaid enrollments for long-term care is inadequate saving for retirement, and planning for the possibility of long-term care. Many Americans, regardless of income, anticipate having sufficient assets to cover their income needs through retirement or plan to continue employment past the age of 67, or perhaps a combination of these two options, until their moment of passing. What few Americans have planned for, however, is the possibility that they may spend one or more decades of their final years of life in a long-term care environment. Ironically, advances in medicine make this possibility more likely. Moreover, personal estates are often configured to anticipate passing wealth to children, rather than setting aside resources for long-term care.

Utilization costs

According to CMS' National Health Care Expenditures Projections through 2015, Medicaid faces:

- a 73.5 percent increase in physician and clinical costs;
- a 140 percent increase in prescription drug spending;

INSIGHT

Bridging the gap between Medicaid and the privately insured

The State of Vermont already had the majority of the items in the Deficit Reduction Act (DRA). Aside from technical changes needed for compliance, there is very little in the DRA for us substantively. However, Vermont's entire Medicaid program falls under two Section 1115 waivers. As a result, we have a greater ability to reform than traditional programs.

The first Section 1115 waiver affects long-term care. It equalizes the entitlement for nursing home and community-based care. The second is the Global Commitment to Health waiver, which includes every other population in Medicaid. The Global Commitment to Health creates a statewide public managed care organization (MCO) which encompasses Vermont's Medicaid program. Our entire population is in the public MCO. For us, "MCO" may be a little different than historical perceptions. The concept is that all Medicaid recipients – irrespective of demographic or healthcare profiling – should receive a number of services that an MCO is required to provide under federal statute. These services include provision of a medical home and member services handbook to each individual. We are doing those things to participate on an equal playing field and make Medicaid more like the other payers throughout one's life. As a public health provider, we don't compete with private payers – but we do behave like one.

Historically, there has been a "welfare" stigma attached to Medicaid. Yet in Vermont, as in many parts of the country, that is no longer the case. We have fewer than 15,000 people on cash assistance – but more than 150,000 people on Medicaid. There are many Medicaid beneficiaries who receive no other forms of public assistance. For instance, we have lots of kids out of college who do not have insurance until they land a good job. Our waiver provides them coverage through Medicaid, and that coverage should feel the same as when they eventually get employer-sponsored insurance. Having a Medicaid card or Catamount Health card should not be any different for them than having a CIGNA or BlueCross card.

Overall, Vermont's Medicaid initiatives are aimed at accomplishing two goals. First, our Blueprint for Health creates partnerships to measure clinical outcomes and to change the way Medicaid pays for the management of chronic conditions across the state. Our other major objective is to reach out to the 9 percent of our population that is uninsured right now, with the goal of helping them access coverage by: a) providing a subsidy for private coverage through their employer, if available; and b) expanding our public programs in a phased fashion, so premiums are tied to a sliding income scale. The non-group market in Vermont is a destabilized market and providing coverage is becoming more expensive as the high-risk cases are the only ones left in this market. Programs to target this population are lifelines for the individuals who could not otherwise afford insurance.

Joshua Slen
Vermont

Director, Office of Vermont Health Access, Agency of Human Services

"As a public health provider, we don't compete with private payers – but we do have to behave like one."

- a nearly 93 percent increase in hospital care costs; and
- a 60 percent increase in nursing home care expenditures.

Total program spending

By 2009, 21 states will spend more than one-half of every new tax dollar on Medicaid; 10 of these states will spend 75 percent or more of incremental revenues on Medicaid. According to the CBO, federal Medicaid spending alone will increase by more than 250 percent over the next decade.

The result: Ballooning growth in enrollment, utilization and overall costs endangers Medicaid's viability. Long-term care, in particular, will overwhelm all other portions of Medicaid. However, Medicaid's current scope of services prevents effective mitigation of health risk or financial liability.

5. Fragmentation

Lacking an integrated delivery system, most Medicaid recipients must navigate through various public and private agencies to access services. In addition, many common Medicaid services, such as mental health services, physical / occupational / speech therapy and at-home nursing services, are not integrated into a care coordination network. Some of these service providers have inefficient – or non-existent – lines of communication between them. Recipients are often unaware of all available resources of assistance or cannot access community-based centers due to lack of transportation, timely availability, childcare or flexibility in the workplace.

On the administrative side, greater coordination between state and federal agencies, as well as appropriate private organizations, is often lacking. Such fragmented healthcare delivery does not provide a single 360-degree view of patient history and medical status, resulting in duplicative services and adverse, even fatal, health complications. Dual eligibility provides an especially poignant example of fragmented delivery and care coordination.

The result: Organizations serving Medicaid work independently in vertical silos, creating inefficiencies, duplicative services and no continuity of care. Service delivery becomes transactional, rather than person-focused.

INSIGHT

The importance of providers and access to care for Medicaid recipients

Our nation's healthcare system is commonly described as fragmented and disjointed; connections are not made between the patient, care provider and insurance provider. However, when you can facilitate or create the appropriate connections for Medicaid recipients, you create a medical home. A medical home provides a single point of provider contact responsible for determining where recipients should go and connecting them with services they need – instead of services they think they need. You don't want patients trying to guess whether they need a neurologist or an orthopedic surgeon. In today's environment, it's pretty daunting for all healthcare consumers to navigate the system, not to mention Medicaid recipients that typically have to overcome challenges such as finding transportation, receiving timely information and accessing child care. Equally important, a medical home gives the provider a holistic view of the patient, including services received and medications prescribed.

Idaho has a mandatory case management program, Healthy Connections, which provides a medical home for Medicaid recipients. This program has been effective at encouraging recipients to use primary care instead of higher-cost, emergency room services. However, states with a low population base, like Idaho, have difficulty attracting health professionals to provide services, which is problematic. In addition to the provider shortage, Idaho faces information technology (IT) connectivity and transportation challenges. The state's IT infrastructure is fragmented and, given the state's geography, it is especially challenging to efficiently transmit information though our technology system. The result is that our transportation costs are high because we have to drive to deliver information. The existing system is not working well, but we are working collaboratively with various payers, providers, employers and consumer representatives – key players in the healthcare community – through our Health Quality Commission. This group is charged with recommending how to develop a statewide, interoperable health information technology system, or health data exchange, and identify best practices in clinical quality reporting. The ultimate goal is to improve our information technology system and incorporate electronic medical records into our system.

Additionally, controlling service utilization is a challenge for Idaho. In a fee-for-service state, what's the motivation for service providers? It's more utilization, not less. Our challenge is to transform the model to pay for outcomes, not just services rendered. In my opinion, managed care will not work in Idaho, but I believe we can incorporate tools from managed care best practices. For example, in our state dental plan, we're going to carve out recipients identified as "average health" and find a commercial dental plan to manage that population via an at-risk contract. Recipients may not receive the same scope of benefits under the current Medicaid program, but they will get better access to more dental providers. Providers will get better reimbursement rates, which hopefully will engage participation from dental providers that typically avoided Medicaid plans in the past.

Idaho's reform is motivated by better health outcomes on all levels – instead of rules and regulations.

Leslie Clement
Idaho

Division of Medicaid Administrator, Department of Health and Welfare

"Idaho's Medicaid reform is motivated by better health outcomes on all levels – instead of rules and regulations."

6. Access to Care

Because provider participation is voluntary, a strong and stable network is vital for access and continuity of care. Yet with government-set pricing and administration hassles, many providers are wary of accepting Medicaid patients, thus restricting recipients' access to care. As Figure 2.5 shows, more than one-fifth of physicians do not accept new Medicaid patients, a rate five times higher than privately insured patients and six times higher than Medicare patients.

One reason for this poor retention is low reimbursement rates. Each state sets its own payment schedule for participating providers, leading to unstable rates from year-to-year within a single state and high-low disparities across states. On average, Medicaid fees remain well below those provided through Medicare. A lack of other incentives, such as pay-for-performance (P4P), is another key factor.

Uncompetitive reimbursement rates and few-to-no incentives discourage many providers from accepting new Medicaid patients–and fail to reward quality healthcare delivery for those that do. This provider environment only compounds the healthcare problems of Medicaid recipients and drives costs that could otherwise be avoided. The fewer participating providers available to recipients, the more likely they are to underutilize needed preventive care. Absent a "medical home," inefficient emergency room utilization for common ailments rises and easily-treated health problems fester into costly crises requiring more intensive care.

In addition to locating participating providers, Medicaid recipients also face challenges in simply accessing healthcare. Parents encounter difficulty finding childcare and taking time off work to visit their doctor. The elderly and disabled frequently encounter problems reaching clinics and hospitals.

According to federal Medicaid regulations, states must provide necessary transportation for recipients to and from providers of medically-covered services. Many states fulfill this requirement by reimbursing transportation providers, such as taxis and private medical vans, for each eligible trip. Other states employ unmonitored fee-for-service transportation programs. Despite the federal mandate, many recipients still have difficulty accessing these services, and transportation departments have difficulty with coordination and financing.

The result: Medicaid recipients often struggle to find participating Medicaid providers, and may have difficulty reaching them due to a lack of transportation or other critical factors. Limited access to care significantly impacts the level and frequency of care Medicaid recipients receive, often resulting in poorer health outcomes.

Figure 2.5: Widening Disparities in Provider Participation

Providers	1996–97	2000–01	2004–05
Medicaid			
Accepting No New Patients	19.4	20.9	21.0
Accepting All New Patients	51.1	51.9	52.1
Privately Insured			
Accepting No New Patients	3.6	4.9	4.3
Accepting All New Patients	70.8	68.2	71.8
Medicare			
Accepting No New Patients	3.1	3.8	3.4
Accepting All New Patients	74.6	71.1	72.9

Source: "Medicaid Patients Increasingly Concentrated Among Physicians." The Center for Studying Health System Change.

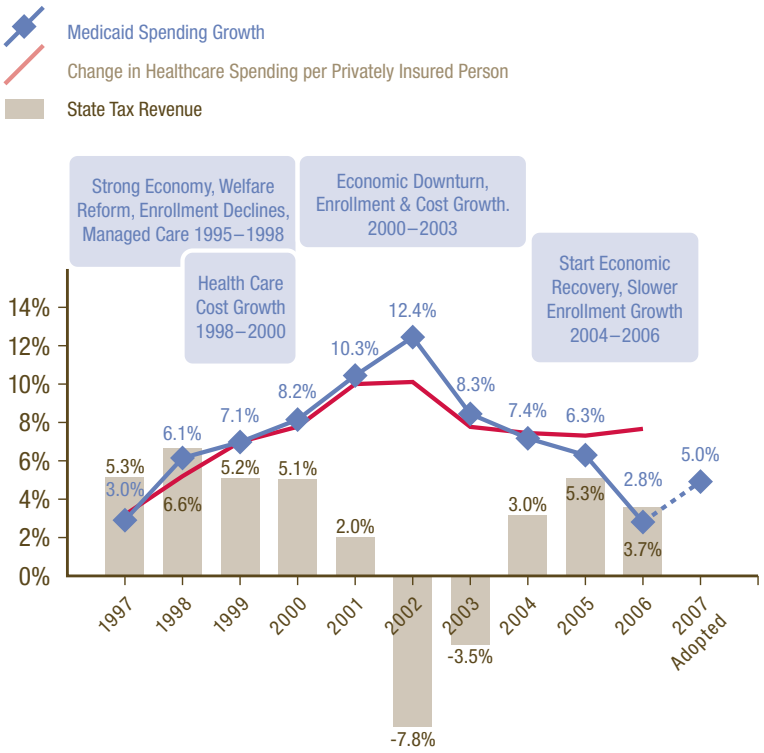


Figure 2.6: Medicaid Spending Growth, 1997 – 2007

7. Unpredictable Federal Matching

Medicaid is jointly funded by the state and federal government. States that meet CMS requirements receive federal funding for a portion of their total Medicaid costs through a Federal Medical Assistance Percentage (FMAP). In fiscal year 2007, FMAPs range from 50 percent to 76 percent. (Federal law sets a 50 percent minimum and 83 percent cap on FMAPs.) The remainder of the funding is the state's responsibility.

FMAPs are calculated annually through a formula outlined in the Social Security Act and vary from state-to-state and year to year. They are inversely proportional to average per capita income – so states with lower per capita income compared to the national average receive a higher FMAP. This formula can be problematic. First, personal income can be a misleading measure of a state's overall economic strength or capacity. But most important, yearly calculations cannot keep up with today's rapid economic changes. A state could be assessed a lower FMAP just as an economic downturn hits, compounding its fiscal woes. Figure 2.6 shows that for the first time in nearly a decade, Medicaid spending growth fell below state tax revenue in 2006, largely due to an economic upswing that dramatically slowed enrollment growth. However, most states also experienced falling FMAPs – increasing pressure on those that rely heavily on federal matching funds. And as the recent Deficit Reduction Act (DRA) reveals, federal funding levels are never guaranteed. Although the DRA opened the door to greater innovation and program flexibility, it also shifted a greater share of Medicaid costs back onto the states.

The result: Medicaid consumes one-fourth of the average state's budget – and shows no sign of letting up without intervention. Yet reversing Medicaid expansion to alleviate budgetary strains is often controversial, challenges the premise of giving those most in need access to healthcare, and leads to lower federal matching funds. So the consequences of Medicaid improvement or reform may outweigh the benefits, especially for states that rely on federal support to remain solvent.

8. State Economic Dependency

Medicaid fosters economic dependency for states. Although maligned for its costs, Medicaid spending funds jobs and significantly increases economic activity. Economists call this the "multiplier effect." Through the federal matching system, states pull in outside dollars for each dollar they spend on Medicaid. These "new" dollars flow through the economy for successive rounds of spending. In general, the multiplier effect holds that state spending on Medicaid goes far beyond the healthcare services purchased by the program itself–eventually inflating the employment rate and economic health of the entire state.

Figure 2.7 charts the return-on-state-investment in Medicaid in 2005. Figure 2.8 shows state-specific economic results from Medicaid spending changes. As figure 2.9 illustrates, the actual impact of the investment is less than the perceived impact due to federal matches. While these numbers seem to encourage *more* spending on Medicaid to drive higher results, it's unwise for states to rely on a federally subsidized program for economic growth and stability.

But there is a deeper problem. The flow of money distorts policy discussions. The focus quietly moves away from improving the health of our citizens most in need. Instead, policymakers quietly ask "how can we maximize the flow of federal dollars into our state?" During interviews with state health and Medicaid officials, more than one interviewee ruefully alluded to their state being "punished" for doing the right thing. In other words, better health outcomes at lower cost sometimes means less federal funding.

Finally, it begs the question of overall public policy–is Medicaid the most efficient way to stimulate a local economy? Does it make sense to favor America's acute healthcare delivery system by investing more money there than in other sectors of the economy?

Consider what could be accomplished by improving the efficiency and cost-effectiveness of Medicaid, then redirecting dollars saved to other social investments such as education, job training, employer tax credits to support higher minimum wages, or even tax relief. For each $1 million, 21 teachers' salaries could be funded; 15 professors at public universities could be paid; or 100,000 library books could be purchased. Rather than rely on Medicaid's trickle-down effect, these investments yield economic benefits that are often longer-term and more stable–reducing the very demand for social safety nets.

The result: States have an inherent bias toward maximizing the flow of federal dollars rather than improving the well-being of recipients. Reliance on these benefits has created a structural barrier to true reform. Moreover, with the exception of home and community-based care, Medicaid has distorted the healthcare delivery model by over-funding and rewarding acute care delivery and inpatient care at the expense of alternate social investments.

Return-On-State-Investment in Medicaid, Fiscal Year 2005		
Total Medicaid Spending	$132.1 billion	
Total New Business Activity	$367.5 billion	Per-State Average: $7.4 billion
Total New Jobs	3.4 million	Per-State Average: 67,086
Total New Wages	$133.1 billion	Per-State Average: $2.7 billion

Figure 2.7: Return-on-State-Investment in Medicaid

State Medicaid Spending	Economic Impact
In 2002, Florida spent $4.1 billion *Federal matching rate 56.43 percent*	• $4.79 billion federal match • Employment impact: 120,950 jobs • Income impact: $4.3 billion • Business activity impact: $8.7 billion
In 2002, Mississippi spent approximately $620 million *Federal matching rate 76.09 percent*	• $1.98 billion federal match • Employment impact: 39,059 jobs • Income impact: $1.05 billion in personal income (generated $60.7 million in tax revenue) • Business activity impact: $2.69 billion in additional economic output; $1.39 billion (2 percent of the gross state product) attributed to federal Medicaid funding
In 2001, Ohio spent $3.6 billion *Federal matching rate 59.03 percent*	• $6.2 billion federal match • Employment impact: 132,028 jobs • Income impact: $4.1 billion • Business activity impact: $11.5 billion
State Medicaid Reductions	**Economic Impact**
In 2003, Florida cut Medicaid spending by $49.5 million	• $71.8 million lost federal match • Employment impact: 1,732 jobs impacted • Income impact: $59 million in lost salaries and wages • Business activity impact: $155 million in lost economic activity
In 2002, North Carolina performed an analysis on the "high" and "low" economic impact of proposed Medicaid cuts State fiscal year (SFY) 2002 ended with a $44.4 million reduction in state Medicaid funding and SFY 2003 saw a $35.5 million reduction in state Medicaid funding.	High Reduction (-$408,309,631 federal + state) • Employment impact: 9,700 lost jobs • Economic output loss: $706,257,420 Low Reduction (-$399,292,466 federal + state) • Employment impact: 9,500 lost jobs • Economic output loss: $690,432,383
In 2003, Ohio considered (but was able to avoid) cutting Medicaid spending by $491 million	• Reduced economic activity: $1.5 billion over a two-year period • Employment impact: 16,500 lost jobs • Fiscal impact: $22 million lost in tax revenue (Includes only state income taxes)

Figure 2.8: Economic Impacts of Medicaid Spending

The federal matching system makes it much easier for states to increase expenditures than to decrease them.

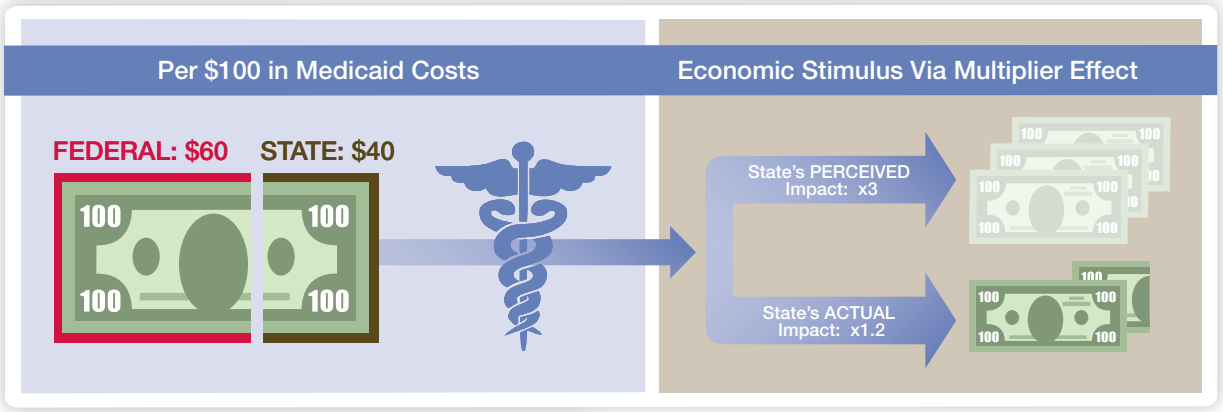


Figure 2.9: The Multiplier Effect

False Issues: Rhetorical traps that prevent transformation

"False issues," topics that often creep into Medicaid policy discussions, sometimes with passion, ultimately confound rather than clarify. By its very nature, Medicaid invites passion and controversy. The dollars are huge, the needs enormous and the personal stories often moving. It's not surprising that the rhetoric surrounding Medicaid can become emotional and confusing. For policymakers, the biggest challenge is sidestepping rhetorical traps that ignite passion, box-in thinking and stymie creative problem solving. Below are a few such examples:

- **Designing programs to optimize federal dollars** – When states focus on Medicaid's impact on job creation, we lose sight of its primary goal: achieving better health for our citizens most in need and acting as stewards for the scarce resources of social charity. There are more efficient and transparent ways to stimulate the economy and promote social advancement.

- **Arguing the merits of government versus free-market solutions** – There are already well-established roles for state agencies and commercial entities serving Medicaid. State Medicaid agencies remain accountable for strategy and results, even when they outsource the health coverage to a third-party health plan. Commercial entities, however, can offer new innovation, better technology and more efficient delivery models. Transformation will come from partnership.

- **Questioning federal involvement in Medicaid** – There will always be a role for the federal government. The issue is how to streamline oversight, providing a regulatory environment while simultaneously fostering innovation, flexibility and accountability at the state level. Do we exercise oversight through broad principles, precise rules, or perhaps a combination of the two? This is an issue of logical governance, not a moral debate.

- **Using Medicaid regulations as a proxy for immigration policy** – Immigration reform is a controversial topic worthy of national dialogue. However, there are better forums for debating, resolving and enforcing immigration policy than in a doctor's office or hospital.

False Issues: Rhetorical traps that prevent transformation

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- **Using Medicaid regulations as a proxy for immigration policy** – Immigration reform is a controversial topic worthy of national dialogue. However, there are better forums for debating, resolving and enforcing immigration policy than in a doctor's office or hospital.

- **Debating the merits of social welfare**– The vast majority of Medicaid recipients are the working poor or their dependents. Should society redistribute the wealth of some citizens to aid those less fortunate? It's a great theoretical discussion, but there are practical reasons why every taxpayer should be concerned about the health of our disadvantaged citizens. It drives high, indirect healthcare costs that affect all of us, imperils our economic competitiveness, and has public health and national security implications.

- **Debating the "morality" of personal accountability**– Within the context of Medicaid, some view "personal accountability" as uncharitable. Medicaid recipients face enormous challenges on a daily basis. But personal behavior remains a primary driver of overall healthcare costs, and the engaged and informed individual remains the single most effective tool to achieve better health. To be clear, some Medicaid recipients will embrace greater self-reliance, while others won't or can't. Policy should never be punitive–no one should be denied necessary treatment. Likewise, no one should face bureaucratic indifference or financial penalties when they manage their health responsibly, live independently or improve their income, freeing up resources to help others. Compassion and personal accountability can coexist.

- **Confusing regulatory jargon for social policy**– The specialized vocabulary of Medicaid prevents transparency of policy. We commonly see meta-debates over narrow statutes and empirical data without evaluation of broader policy goals. Regulatory language should not exclude the public (or legislators) from policy debates, or muddy the issues.

- **Considering Medicaid without its broader social context**– Medicaid does not exist in a vacuum. Rather, it coexists with other social programs and with the poverty and personal circumstances that lead to poor health.

To achieve breakthrough transformation in Medicaid, we need to stay focused on the most effective and efficient ways to improve the health status of our disadvantaged citizens, rather than get caught in rhetorical traps.

INSIGHT

A national perspective on Medicaid

Tom Scully

Former Administrator,
Centers for Medicare &
Medicaid Services

"My view is that most states think that coordinating care and creating financial incentives to keep people healthy is a good strategy."

Instead of one unified program, Medicaid is 50 different programs – and should be dealt with as such. So if you're a state Medicaid administrator, what should you do? First, design rational, creative incentives for restraining unhealthy behaviors. Next, understand and monitor your recipients – especially the high-cost ones. Then, approach CMS with an innovative demonstration based on those things.

Most states have help. Today, private businesses play a huge role in Medicaid – and it's still expanding. Approximately 28 million recipients are in managed care plans, and membership has increased about 5 percent since 2003. Why? Because most states are realizing that they don't really know how to manage these populations; third-party payers will do a better job. Any state thinking about controlling its Medicaid cost trend will hire a third-party and put them at some degree of financial risk.

Most states have moved toward setting up their own fund – whether they call it "managed care" or not – and have private payers manage it, like an ERISA plan. Managed care does not necessarily mean an HMO with no deductible and no co-payment; it could be a wellness-based plan with basic healthcare coverage, a $400 or $600 deductible (or some parameters to follow healthcare guidelines) and a personal services account where the recipient can use any unspent funds for other purposes. There are numerous ways to design such plans.

The real issue is: who can manage recipient care better? A bureaucrat writing checks out of the state's trust fund … or a health plan – whether an HMO, PPO or more open-ended disease management plan? My view is that most states think that coordinating care and creating financial incentives to keep people healthy is a good strategy. And, frequently, a higher-deductible plan where individuals keep the cash if they achieve desired health goals is equally worthwhile. States can create competition through a similar bidding process the private sector uses for choosing employee health plans. Then, you manage each vendor and ensure you have the right metrics in place to gauge their performance. Most states have the flexibility to create incentives and better understand their recipients – but they don't design their plans with these tools in mind.

Transformation starts with structuring the incentives and plan designs at a state level, so that you give incentives for everybody to succeed. Look at each population differently: low income; elderly nursing home patients; and the disabled. Spending and program designs are completely different in all three.

Chapter 3: The Ideal Medicaid Program– Four Guiding Principles

If I could design Medicaid from scratch, what would it look like? Today's systems are not designed properly and incentives are not properly aligned. These things need to be improved. Yet, how do you align the incentives to get better measurable outcomes at a lower cost? What metrics do you use? And what is the baseline for measuring future costs? True reform happens when you ask such questions.

–Alan Levine
Florida

Former Secretary, Agency for Health Care Administration

The ideal Medicaid program should achieve better health for recipients at lower cost, and promote the personal empowerment and social advancement that naturally occur through better health.

Unfortunately, the historical opportunity to use Medicaid as an economic stimulus package has corrupted its core purpose. What does the ideal Medicaid program look like? The answer is not obvious.

One key challenge for policymakers is to reconcile the dualistic nature of healthcare. On the one hand, healthcare is an exercise of numbers that describes health outcomes, actuarial trends, characterization of risk and overall costs. Best practices and evidence-based medicine come from the statistical review of thousands of outcomes. The effective use of technology requires common standards and protocols for storing, transmitting and editing personal health information.

Belying cold statistics and technology, however, the art of healing is a profoundly personal and individual matter. Health outcomes are achieved one person at a time. Every individual has unique health and social needs specific to their education, location and personal circumstance. More broadly, TANF, disabled and elderly populations have distinct needs, and each state faces unique challenges.

Our interview findings and research suggest that no one program design can sufficiently serve the needs of fifty separate state Medicaid programs, much less the unique needs of all recipients in even one state. Thus, the ideal Medicaid program needs to balance normative best practices in health metrics and technology with the flexibility to provide highly personalized coverage at the point of delivery.

Another challenge for policymakers is to determine which innovations from private sector healthcare can be successfully applied to Medicaid. In some cases, best practices can be lifted from commercial populations verbatim. More often, some translation is required. Disease management, a successful technique for optimizing health outcomes and reducing the cost of chronic diseases, provides a case in point. In a Medicaid population, chronic conditions cannot be managed without considering the *whole person*: the co-morbidities, the mental health of recipients and social conditions that would otherwise prevent one from achieving effective self-care. A person-centric program requires advanced technologies and teamwork that extend beyond care management nurses to include provider engagement and social service agencies that are not typically considered part of our traditional

system. Moreover, since a majority of Medicaid recipients lack a permanent address or telephone number, this multi-disciplinary team must be prepared to deploy in close proximity to the people who need their support.

Finally, Medicaid cannot be transformed without addressing the financial incentives that drive irrational policies and behaviors at every level, from the federal government to providers and recipients. Policymakers at the state and federal levels must be prepared to confront, and discard, a wide range of false issues that have plagued the Medicaid system, such as the use of Medicaid funds for economic stimulus while (sometimes simultaneously) questioning the ethics of social charity and welfare. These issues make attractive political soundbytes, but merely confound public policy. At the individual level, we must be prepared to confront binary tests of eligibility that create a revolving door for Medicaid's TANF recipients. Public policy should never punish citizens for earning more or working harder, for example, by entirely dropping their Medicaid coverage when they reach a threshold income.

Disease Management in a Medicaid Population: The story of a 6-month-old with asthma

If a baby suffers from asthma and belongs to a middle-class family with commercial health insurance, there is a good probability that his/her parents will receive counseling and support through a disease management program. That support will likely consist of a phone call from a highly trained nurse who can provide assistance, answer questions and guide the parents through the practical steps to manage their child's chronic condition. In addition, health education literature and access to a professionally-reviewed health web site will most likely be available. If their provider is not utilizing evidence-based medical guidelines, or best standards of care, the disease management program provider may follow up with the provider for further discussion, or even help the parents find a highly qualified specialist.

In the Medicaid world, however, this experience is much different as real-life issues challenge the standard disease management approach. A case example familiar to one of our authors illustrates this well. A baby with severe asthma required multiple visits to an emergency room. However, the single mother caring for her son faced other issues that confounded treatment: a personal struggle with alcoholism, a rural location with a distant provider and another son who had just burned down the neighbor's garage.

Some of the standard advice that would be provided to parents of asthmatic children, like eliminating carpets in favor of a regularly vacuumed solid floor to reduce allergens, was irrelevant in a house with a dirt floor and a coal-fired heater.

To provide appropriate preventive care for the child, the entire situation must be addressed holistically, rather than handled in silos by multiple agencies working separately. However, the money that could be saved by avoiding one or two emergency room visits could easily pay for non-emergency transportation to a doctor, prescription medications and a couple months of day care for her children.

Today, most Medicaid programs focus on, and pay for, expensive acute care without addressing the underlying drivers of poor health: poverty, mental illness and sub-standard living conditions.

Framework for Transforming Medicaid

In order to transform Medicaid, states must implement a common framework that creates a reinforcing and supportive environment for improving health and financial status.

Four Guiding Principles

I. Align structure and incentives

Properly align the flow of funds to create a system-wide bias toward better health at lower cost. States, providers and recipients should all have a vested financial interest in achieving the *right* program design and outcomes.

II. Promote social advancement

Empower recipients to advance in society and "graduate" from the Medicaid program by fostering independence, self-respect and personal responsibility. Address not only healthcare needs, but also the underlying poverty and social conditions that contribute to and amplify poor health.

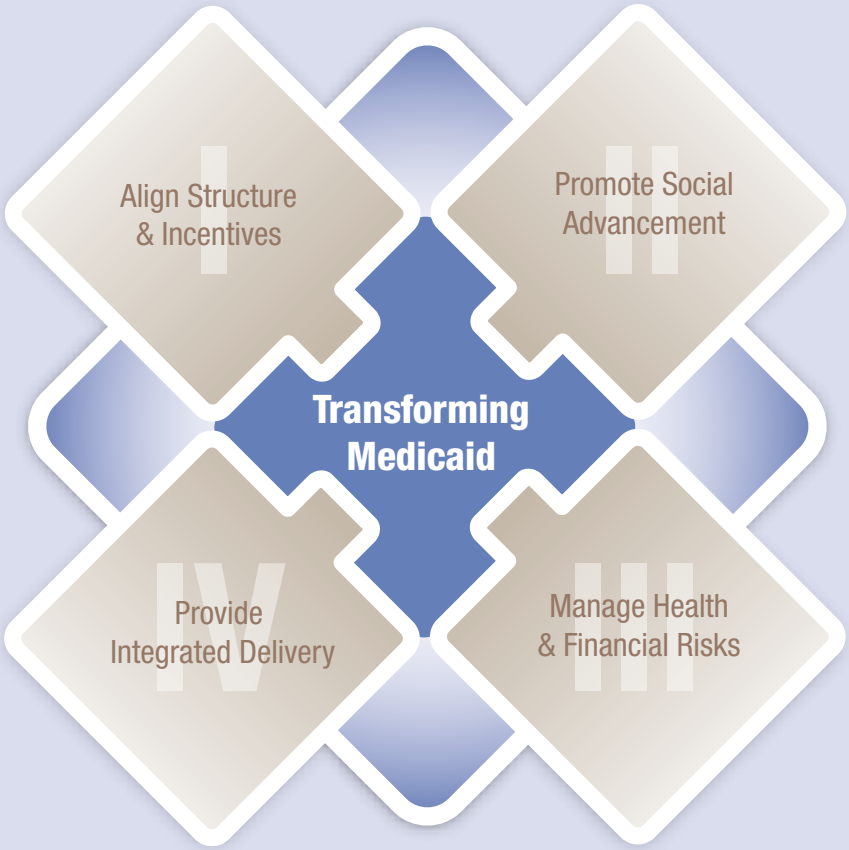
III. Manage health and financial risks

Accurately measure the ongoing health and treatment outcomes of the entire population, and manage, measure and adjust programs based on the data.

IV. Provide integrated delivery

Utilize technology and ancillary services to create efficient, person-centric services that better coordinate healthcare delivery and social services, while eliminating the silos present in Medicaid and the current healthcare system as a whole.

Based on our research and SHPS' experience serving government and commercial sectors, SHPS and CHT have developed four guiding principles that address the diversity and standardization required to transform Medicaid. The framework allows for flexibility within each state while conforming to crucial principles that provide a litmus test for sound policy and provide a structured path for program design. Each of these principles is described in further detail on the following pages. Taken individually, each principle has value, but they act synergistically. To truly transform Medicaid, the adoption of all principles is necessary.



These four principles create the best value and outcomes for all stakeholders.

Principle 1: Structure and Incentives

In transforming Medicaid, proper alignment of structures and incentives is perhaps the most challenging principle to perfect. Incentives in today's Medicaid programs are misaligned from the top-down. States receive federal funds for total program expenditures that boost economic activity, encouraging expansion rather than efficient operations. Providers are discouraged from participating in the Medicaid network due to low reimbursement levels – and those that do participate must focus on quantity (seeing more Medicaid patients) rather than quality (spending adequate time with these patients and following evidence-based care) to make up for this shortfall. And for recipients, the threat of losing Medicaid coverage discourages social advancement and offers no rewards for choosing healthy lifestyles that reduce the very need for healthcare.

An optimal Medicaid program's architecture will direct resources so that the common goal, at all levels, is to improve the health outcomes of Medicaid recipients and decrease costs.

State governments leverage technology and tools, from the public and private sector, to expand recipient access and boost performance results. The savings realized through these efforts are reinvested into social programs that address the underlying social conditions that often drive poor health and demand for Medicaid.

Recipients are encouraged to change unhealthy behaviors and begin making responsible healthcare decisions. Additionally, recipients are motivated to advance in society and transition out of the Medicaid safety net and into the mainstream healthcare system.

Providers are enticed to participate in the Medicaid network and not only treat recipients, but also provide high quality care that's on par with the privately insured. Provider incentives can include financial rewards through pay-for-performance programs or profession-based incentives, such as reimbursement for medical conferences or continuing education.

Instead of simply *reacting* to current needs or crises, Medicaid programs can make *proactive investments* toward achieving future goals at the state-, provider- and recipient-level including:

- Rewarding healthy decisions and encouraging individual responsibility at the state and recipient level;
- Offering incentives to providers that deliver evidence-based care through well-designed pay-for-performance programs; and
- Improving performance continuously through CMS waivers, pilot programs and public-private partnerships.

Medicaid will continue to be fundamentally broken until its structures and incentives are properly aligned to provide quality, cost-effective healthcare for recipients. Yet undertaking innovative experiments in program design not only uncovers best practices, it increases the momentum toward true Medicaid transformation.

INSIGHT

Structure and incentives in Medicaid

New Mexico has weathered the downturn in the economy a little better than some other states. We have a faster growing economy, which means more revenues as well as increased revenue from oil and gas. However, because our economy is growing, New Mexico has endured some tough times with losing federal matching funds. We used to receive about a 75 percent federal match – now we receive approximately a 71 percent match. Four percent over three years is a lot of money to lose, and we're going to lose another percentage point going into next fiscal year. There is a price to pay for prosperity when it comes to Medicaid funding.

One of the problems with the current funding structure is that it's difficult for a state to absorb a change in the federal match quickly. New Mexico has remained fiscally healthy because we've done major cost containment and cleanup; and because we've generated enough revenue and our legislature is committed to the Medicaid program. They've generously committed approximately $80 million just to keep the program at a reduced level.

I'd like to see a proposal, backed by our congressional delegation, that no state has to take more than "X" percent federal match deduction in any one year. This would help even out the changes. Secondly, we've not been able to spend all of our State Children Health Insurance Program (SCHIP) money, not because we don't have kids who need that service, but because we had already increased our federal poverty level for kids up to 185 percent. We keep sending money back to the federal government, not because we couldn't spend it, but because of the way the SCHIP program is set up.

Another issue is that in order for a person with a disability to maintain their insurance, they can't make more than a certain amount. Even in the working disabled program, there are limitations. The country's entire system of health and human services is designed to keep people poor. If you're really, really poor, we can see our way to help you. But if you have enough to actually go to the grocery store, then we shouldn't help you – you should just deal with it. So the concept, "if you're earning minimum wage and you're on Medicaid, you may be better off than if you're earning $12 or $14 an hour with private health insurance" is, unfortunately, true.

As a result, people choose to not advance above that level, to stay on the disabled program or to only work so much so they don't lose their healthcare coverage. Some recipients on SSI or SSDI know exactly how much they can make before they lose their disability – and their disability is their key to Medicaid. For many people, access to either hospitalization or medication is critical. It's more important to make less money and have access to those medications and healthcare services.

Pamela Hyde
New Mexico

Secretary, Human Services Department

"I'd like to see a proposal, backed by our congressional delegation that no state has to take more than "X" percent federal match deduction in any one year."

Principle 2: Promote Social Advancement

Personal empowerment is multi-faceted. For a disabled person, empowerment may mean living at home with assistance, rather than in a long-term care facility. For an individual with diabetes and failing eyesight, empowerment may mean self-care education, home diagnostic equipment and assistance with transportation to doctor appointments. Personal empowerment not only aligns with our social values, it saves money by decreasing the use of our acute healthcare system in favor of common sense.

One aspect of empowerment is built around the principle of healthcare consumerism – a personalized approach that fosters greater personal involvement in one's health, improves health behaviors and encourages prudent healthcare purchasing patterns. Its principal tenets are *behavioral change* and *individual health ownership*. Healthcare consumerism programs must work for the ill and the healthy, the passive and the engaged, the technology-savvy and computer-illiterate.

A consumer-centric Medicaid model supplies efficient, effective and empowering healthcare to recipients, while providing state sponsors with fiscally-sustainable delivery strategies by:

- Providing social and economic support to improve recipients' sense of personal relevance;
- Integrating families and communities, perhaps using non-traditional contact points or strategies to achieve program goals;
- Leveraging best practices, technology and evidence-based medicine to achieve the best possible healthcare delivery and outcomes; and
- Relying on flexible building blocks for program design, including personal care accounts, wellness promotion, disease and case management, information and decision support, and incentives or rewards.

For Medicaid populations, altering unhealthy habits presents unique challenges. Many recipients cannot afford preventive care, treatment and other health-related items, such as vitamins, outside of available benefits. When seeking care, they are more likely to utilize costly and/or inappropriate resources, such as visiting the emergency room for non-life threatening health events. These habits combined incur significant, yet avoidable, costs.

Fostering individual ownership over one's health can mitigate this problem. One approach to health empowerment in Medicaid is the health opportunity account. Similar to an employer-funded healthcare spending account, it subsidizes needed healthcare services outside of existing benefit plan structures. In a recent Gallup poll, 67 percent of Medicaid recipients expressed interest in health opportunity accounts. Sixty-five percent indicated a willingness to change behaviors and go to the doctor's office (as opposed to the emergency room) if it resulted in financial incentives for the recipient.

A transformative approach to Medicaid empowers recipients to take greater control over their healthcare – which often yields longer-term gains for the recipient and state sponsor than benefits alone.

INSIGHT

The role of personal responsibility in Medicaid

Clearly, individuals and families are ultimately responsible for their own choices regarding lifestyle and using the resources available to them to make educated choices. In terms of Medicaid, it's difficult to determine where society's role and an individual's responsibility begin and end, beyond the transfer of knowledge. If the question is whether we should deny coverage or payment based on lifestyle choices, I'd generally answer, "no." The fact is that in almost all cases the individual is going to get treatment and the cost will be covered by those who pay for services.

There will be many questions regarding what lifestyle choices are targeted and where lines are drawn. For example, I believe some studies indicate moderate drinking can improve longevity, but I suspect this activity can be more or less dangerous based on other factors, such as pregnancy. Does a motorcycle rider who suffers head injuries receive paid care? Even with a helmet, the activity is known to be high risk. Also, it's not always clear that the lifestyle activity is what results in the need for care. Ninety-five percent of bladder cancer is a result of smoking, however, I don't know that on an individual basis it can be determined who is in the 95 percent group and who is in the five percent group. What about a smoker who quits? Is he or she permanently labeled as uninsurable based on prior activity? Where do you draw the line? The outcome is a system that becomes even more complex, and frankly, I don't know that I've met a person who has not knowingly engaged in some high-risk activity. We actually denied payment in a now-defunct state program for conditions that resulted from commission of a crime (including running stop signs) and skiing accidents. However, care was not denied, and I'm sure we, as premium payors, covered the costs, and I doubt we had any impact on people's lifestyle choices.

Providing positive incentives to encourage healthy behaviors may be a better option, although if not constructed correctly, costs may increase. If we provide incentives to those who would make the right choice anyway it will have little impact on those whose choices we're attempting to change. Benefits are often long term – and costs are often short term. If this holds true, politically it will be difficult to maintain incentives long enough to realize positive results, even though it may be the correct thing to do. As Medicaid has become larger in both enrollment and expenditures, it has become subject to greater political pressure. As administrations change, national agendas change, resulting in different, often contradictory guidance. Likewise, our systems have to reorganize, commitments are renegotiated, and a great deal of time is spent trying to maintain the political integrity of the program. Reacting to these external forces makes it increasingly difficult to move important innovative program initiatives forward.

Michael Deily
Utah

Former Director, Division of Health Care Financing, Utah Department of Health

"The fact is that in almost all cases the individual is going to get treatment and the cost will be covered by those who pay for services."

Principle 3: Manage Health and Financial Risks

If someone put you in charge of a $5 billion health plan, what information would you need to run it effectively? How would you measure and manage financial risk? What tools would you need to be successful? In assessing state Medicaid programs, the following questions must be answered:

- *What are the prevalent health risks in the population*?
- *What factors drive these risks*?
  - Medication compliance
  - Compliance with evidence-based medical guidelines
  - Physician involvement/support
- *Is the overall health of the Medicaid population improving or declining*?
- *Are we achieving better health outcomes and cost savings through our interventions*?
- *How have our interventions impacted current trends*?
- *Are our programs and policies aligned*?

Regardless of whether the insurance underwriter is a health plan, a self-insured employer or a state Medicaid agency, the requirements for best practice risk management are the same. Just as the pilot of a commercial jet needs instruments to fly the plane, a Medicaid director needs a powerful statistical dashboard to manage the program. To be successful, this dashboard must have a number of standard capabilities:

A **Medicaid health index** providing a single, aggregate measure that characterizes and quantifies the health of the entire state Medicaid population, as well as component scores that identify the major population health issues that contribute to the overall score. To make this health index meaningful, however, it should also directly tie back to projected future healthcare spending.

A **personal health index** that builds a complete picture of health status and risks for each individual recipient, segmenting portions of the population for targeted health interventions like disease management programs. Additionally, this individual risk score ties directly back to the aggregate index for a comprehensive total risk approach.

The ability to drill down and identify underlying risk drivers – such as access to care, provider performance, lifestyle / behavior and medication compliance – to determine effective interventions and guide policy decisions around program design.

The ability to continuously update program metrics and use these metrics not only for reporting, but as triggers to drive day-to-day care management and social interventions.

All states have some formal Medicaid measures in place today; however, these measures may not be complete, timely or effectively linked to daily operational and intervention decisions. In

addition, states partnering with multiple health plans may not be able to obtain an accurate comparison across populations. At the federal level, CMS has limited authority to standardize data collection and requirements.

Because many Medicaid programs today lack an accurate or complete understanding of the financial and health risks of their current covered population, they are unable to:

- Adjust program design or identify interventions with the greatest payoff;
- Hold third-party vendors and managed care companies accountable for quality of service;
- Hold providers accountable for delivering evidence-based treatment; or
- Manage their Medicaid programs with the rigor that can be expected and achieved in a commercial health plan of similar size.

Data-driven Medicaid programs offer a clear picture of what's working and what isn't, allowing states to continuously adapt and improve operations based on population changes.

Principle 4: Provide Integrated Delivery

Integrated delivery is both a philosophy for designing public health programs as well as an organizing principle for implementing the technology and processes these programs need.

At the philosophical level, it can be summarized as *people, not procedures*. Historically, Medicaid programs have been designed to mechanistically administer payment for approved medical procedures and services, regardless of whether they were logical or cost effective within a broader context. To be effective, consumer-centric programs need to address the whole person and require a high degree of integration and coordination across programs. Services delivered through silos simply do not work as well. To make an integrated approach work, technology must support the creation of a 360-degree portrait of recipients' health status – a personal health record – at any given time.

All the relevant touch points of a Medicaid recipient – enrollment, utilization review, provider visits, participation in disease and case management programs, and services provided by other social agencies – should be able to appropriately exchange real-time information. The recipient's personal health record should be readily available to all relevant caregivers in order to eliminate costly duplicative services.

In practice, integrated delivery also means that vendors serving the Medicaid market – Medical Management Information System (MMIS) providers, managed care providers, health systems and third-party services – must work collaboratively. The robustness of underlying technology becomes a critical factor in selecting and working with these vendors.

Breaking down the silos in today's healthcare system not only improves patient care and outcomes, it raises the efficiency and cost-effectiveness of the delivery system itself.

INSIGHT

The importance of integrated delivery in a Medicaid program

Mark D. Birdwhistell
Kentucky

Secretary, Cabinet for Health and Family Services

"We want to provide case management to a larger population and not have people receiving duplicative services."

I spent 17½ years working in Medicaid, left in 1994, and returned in 2004. Alarmingly, when I returned I found not much had changed. My absence, however, provided me the opportunity to appropriately use industry best practices, data systems and appreciate the benefits of care and disease management – two programs that are typically nonexistent in most state Medicaid programs. Medicaid comprises 22 percent of our Commonwealth's budget, and it basically lacked infrastructure, the ability to implement best practices from the commercial sector, and, until the recent passage of the Deficit Reduction Act (DRA), it lacked the flexibility to allow policymakers to structure their programs to meet the varying needs of unique populations.

Kentucky is seeking a more collaborative approach with other social service and human support agencies. Our experience shows that you can break down administrative and funding silos internally and create strategic partnerships between cabinet agencies using the flexibility offered by the DRA. I think this approach will result in long-term budgetary savings for both the state and federal government. For example, with our case management offerings, we found that each silo organization had its own set of case managers serving a small population. We want to provide case management to a larger population and not have people receiving duplicative services. We envision a cross-disciplinary case management team looking out for the social, educational, physical and mental health of Medicaid recipients through a single delivery model – one that is all interrelated.

We're using technology to prove the mantra "you can't manage what you can't measure" and to stretch everybody's thinking capacity about e-health. We have to push an e-health initiative from a global perspective because e-health equals lower cost and higher quality healthcare. Just as we're breaking down bureaucratic barriers internally between our social services delivery agencies, we need to do the same thing using the technology available to us. Electronic health records will provide multiple opportunities to eliminate duplicate services and potentially save people from adverse reactions and inappropriate treatment.

This is an iterative process, but the foundation is being built with a 21st century, best practices infrastructure. With the passage of the DRA, we now have the federal flexibility to allow us to customize programs and Kentucky uses this flexibility to break down the silos of the administrative agencies. Also, we want to use the available, appropriate technology to track a recipient who taps into the system in the department for community-based services, who also shows up in the health department, the community mental health center and the local health clinic. If they had an MRI two days ago, the MRI is electronically transmitted to the subsequent provider and there's no reason to have a duplicate service.

Building a truly integrated, holistic system of care management, technology and financing is fundamental to transforming the current system and enabling our society to reap the benefits and improve quality of care in the ultimate sense.

Chapter 4: Practical Steps for Transforming Medicaid

I would divide Medicaid into three programs with differing eligibility criteria, use private carriers to administer them, provide more choice, offer incentives for staying healthy and emphasize prevention. Medicaid can be a proactive force in reforming healthcare overall – and that point is often overlooked in public policy discussions.

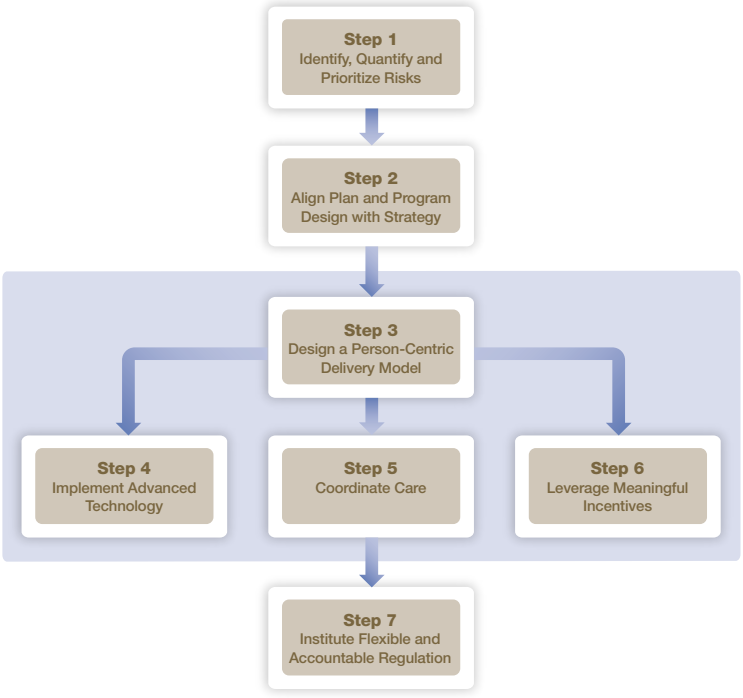
– Michael Leavitt
U.S.

Secretary, Department of Health and Human Services

Medicaid is not one program – it's 50 programs plus the territories. If you're a state Medicaid administrator, what should you do? Try your best to design rational, creative incentives for people to change unhealthy behaviors.

– Tom Scully, Former Administrator, Centers for Medicare and Medicaid Services

In the previous chapter, we outlined four fundamental principles that can transform Medicaid into effective, efficient and sustainable programs. Moving from philosophy to practical application, this chapter offers step-by-step recommendations for implementing and supporting this framework, while also showcasing innovations individual states have already undertaken. It begins with an overarching matrix that matches each action step to the four core principles; next, each step is examined in greater depth, offering guidance, key questions and potential pitfalls; and finally, we touch on the need for multi-level action to transform a program as complex as Medicaid.



Our framework was developed by looking at innovation taking place within Medicaid programs today, as well as best practices in health management from the private sector. For those who have labored long within state agencies, we admit that we have taken an inherently complex process and simplified it. In practice, government planning is messy, complex and highly iterative.

Our belief is that good policy starts with clear, total population health analytics. Ideally, each state should understand not only the health status of their Medicaid recipients, but in fact, their entire population. Good metrics drive strategy by identifying the largest drivers of health and financial risk, and the underlying causes of risk. Program design and plan coverage need to align with risk.

With aligned programs in place, the next challenge is to consider delivery models. A key theme in our interviews with state officials was their desire to achieve better coordination across all social programs with Medicaid and to create more effective integrated delivery models. Yet the process of government, by its very nature, encourages fragmentation of programs.

Before any state agency commits dollars to technology, care coordination or the design of financial incentives, there should be a clear vision of how Medicaid services should be coordinated and delivered, and how Medicaid services fit into an overall framework of social services.

- *How will providers, care management services and state agencies share information?*
- *What are the key touch points for a recipient receiving services funded by Medicaid?*
- *What are the boundaries for sharing a personal health record?*
- *How can the system reward recipients for healthy behaviors?*
- *How will health analytics trigger interventions?*
- *How will security be guaranteed?*

Once these questions are answered, states are better positioned to evaluate their options for implementing technology, care management programs and financial incentives. Then states can effectively evaluate existing legislation and regulations in a holistic rather than piecemeal fashion, and develop a strategic agenda.

Why place regulatory reform at the end of the process? Truthfully, transformation policies will be iterative, and continually refined in parallel with planning. However, our belief is that public health policy should be data-driven and strategic. That is – metrics, strategy and operational delivery models ought to drive how we design statutes and regulation. Today, the opposite is often true.

Our hope is that these practical steps will serve as a springboard from which states can brainstorm, design and implement solutions that lead to tomorrow's best-in-class Medicaid programs.

Lessons Learned from the Private Sector

Some employers are substantially more effective at managing the health of their employees than others, and enjoy significantly lower healthcare costs as a result. A study sponsored by the National Business Group on Health found differences of as much as $1,500 per employee per year in cost of comparable health coverage between major corporations, even adjusted for actuarial variables such as age, sex, type of work and geography. Organizations that efficiently manage the health of their employees have a substantial competitive advantage in the marketplace. Similar logic applies to states and their future economic competitiveness.

So what accounts for the huge disparities between organizations? SHPS' research and experience with large self-insured corporations suggests the following best practices:

- Possess a strong point-of-view about healthcare, linked to overall business goals;
- Utilize health analytics to measure and monitor the health of the entire population, assess programs and monitor provider performance;
- Develop long-term strategies to reach their goals, and deliberately sequence the introduction of new programs to reach these goals;
- Integrate all aspects of health management including plan design, financial incentives, prevention, administration and communication, to work together synergistically;
- Implement care management services as an integrated continuum ranging from wellness programs to utilization management, disease management, case management and a 24-hour nurse line;
- Employ strong financial incentives that reward employees for healthy lifestyle habits and program participation;
- Communicate with employees and covered dependents continuously with relevant personalized information;
- Partner with vendors that can serve as strategic partners in an integrated delivery model, and hold them accountable for out-comes – not activities; and
- Select, monitor and make adjustments to provider and network performance by assessing provider quality and efficiency, rather than cost per procedure.

We are not advocating that state Medicaid programs operate like large self-insured corporations – the needs of Medicaid recipients are far more complex. However, the process for developing and implementing an effective healthcare strategy is similar.

Step 1: Identify, Quantify and Prioritize Risks.

The ability to measure, manage and act on health and financial risks is a core principle of Medicaid transformation. To achieve this goal, risk scorecards are invaluable tools. Such a scorecard provides in-depth analysis of a total population's key risk drivers and offers guidance on program and policy design.

What does a health risk scorecard look like? Figure 4.1 illustrates one model that SHPS has used with corporate employers, government agencies and Medicaid administrators. While there are several models circulating among states, all risk scorecards should highlight the health risks in a population, prioritized high to low, and benchmark them against a standard population.

A risk scorecard allows states to design the right framework of programs, services and incentives to address the unique needs of their Medicaid population. It also illustrates the direct correlation between clinical health and return-on-investment (ROI). *In fact, for every one point of overall risk, there is an average of $1,000 per-person-per-year in healthcare expenditures; so lowering a risk score by one point in a chronic population of 100,000 recipients translates into $100 million in savings.* The total risk score also provides a comparison with an overall benchmark standard, with 1.0 being baseline for a random population. On average, the total risk score is 2.5 times higher in a Medicaid population versus a privately insured population.

States need to consider several issues for their risk scorecard:

- *Does the risk profile represent the entire Medicaid population, or only portions?*
- *How does the claims record account for recipients who move in and out of the Medicaid program?*
- *Are claims records provided by different managed care providers within a state consistent and complete?*
- *Is there a way to improve scorecard accuracy through the addition of clinical rules?*

SHPS' sample scorecard results from more than 3,000 separate clinical rules tied to chronic disease and evidence-based medicine, above and beyond standard off-the-shelf medical analytics.

We've got to build an infrastructure where we take data and learn from it. We've got to have a place to give it to a person or organization – and know that change is going to be effected.

– Robert M. Kerr, Director, South Carolina Department of Health and Human Services

Figure 4.1: Sample SHPS Risk Management Scorecard

Disease Class	Incidence Rate	Total Risk Score	Primary Disease Score	Co-Morbid Disease Score	ERG/PRG	EBM	Percent of Medical Costs
High Risk Management	2.7%	21.209	2.708	8.866	7.066	2.569	18.4%
Stroke/TIA	3.5%	19.402	2.707	6.809	6.500	3.385	10.8%
Congestive Heart Failure	3.5%	22.045	3.032	7.297	7.204	4.512	8.3%
Diabetes	8.5%	13.639	1.774	3.502	4.636	3.727	10.8%
COPD	1.5%	13.899	3.282	4.268	4.779	1.570	3.0%
Coronary Artery Disease	2.2%	11.294	1.932	2.830	4.204	2.328	2.2%
Atrial Fibrillation	0.2%	8.153	0.862	2.078	4.074	1.139	0.3%
Asthma	8.6%	5.590	1.405	1.911	1.728	0.546	6.3%
Hypertension	6.6%	6.167	0.320	1.903	2.950	0.994	5.9%
Hyperlipidemia	2.3%	5.493	0.366	1.634	2.707	0.785	3.7%
Low Back Pain	6.6%	4.421	0.768	1.529	1.886	0.239	4.5%
Total	46.2%	10.732	1.557	3.440	3.822	1.914	74.1%

The **incidence rate** measures the prevalence of conditions in a population, providing an at-a-glance summary of the most common diseases.

The **total risk score** combines risk scores from the primary condition, co-morbid conditions, predicted future costs and compliance with evidence-based medicine.

The **primary disease score** is the risk score of the listed disease/condition.

The **co-morbid disease score** is the risk score from present co-morbid condition(s) that affect the primary disease.

Episode risk groups (ERG) / pharmacy risk groups (PRG) are actuarially validated predictions of future healthcare costs based on medical and pharmaceutical claims.

Evidence-based medicine (EBM) measures compliance with EBM guidelines (scientifically proven ways to effectively treat and manage health problems).

The **percent of medical costs** identifies the most costly conditions within a population.

REAL WORLD APPLICATION

Rhode Island's Health Indicator System: Data-driven Medicaid management

In 1999, Rhode Island developed the Health Indicator System to assess, design, monitor and evaluate its Medicaid program (RIte Care). Metrics are based upon: 1) existing public health data sets; 2) state surveys of Medicaid recipients; and 3) Medicaid Management Information System (MMIS) data. To illustrate any disparities in health outcomes, the indicators compare recipients to the privately insured. Rather than simply collecting this data, Rhode Island incorporates it into RIte Care's design and ongoing evaluations of services. Medicaid directors and staff receive monthly reports of its results, allowing stakeholders to identify deficiencies and monitor performance.

The Rhode Island Department of Human Services even published *Design of a Health Indicator System: A "How-To" Manual for State Medicaid Programs* (www.dhs.state.ri.us) to help other states implement similar monitoring systems. It asks: "Is our public investment in providing health coverage through Medicaid improving the health outcomes of the population served by the program? How do the health outcomes of this population compare to other groups of citizens? It is critical for state and federal policymakers to be able to answer these questions."

While an overall health scorecard is useful, it is not yet actionable. Two populations may have identical health profiles, but different risk factors driving poor health. To be effective, Medicaid programs must proactively identify and mitigate risks on a continuous basis. Three questions must be addressed to understand a population's underlying health and financial risks:

- *Are there gaps in care?*
- *Are recipients utilizing healthcare resources effectively?*
- *Are providers delivering care based on evidence-based medical guidelines?*

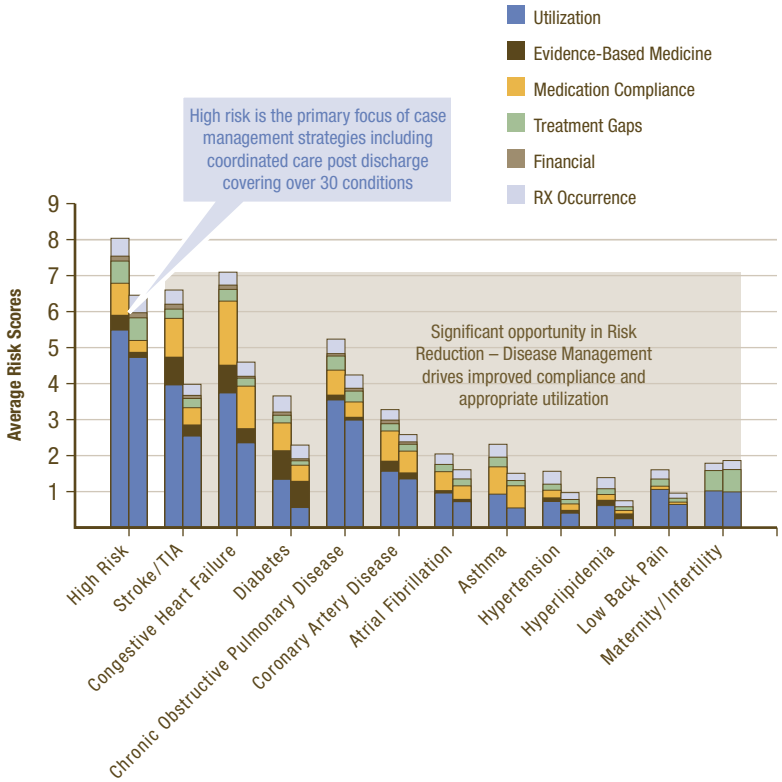
Ongoing risk profiling is a best practice that enables states to answer these questions by continuously monitoring the covered population for elevated risk levels. Key factors in the risk profile should include:

- Appropriate utilization of healthcare resources;
- Compliance with prescribed medications;
- Comparisons against evidence-based medical guidelines to identify treatment gaps;
- Level of provider involvement and support;
- Related financial implications; and
- Medication usage vis-à-vis approved formularies.

Figure 4.2 illustrates the value of using predictive analysis to identify a population's leading risk factors. Due to frequent disparities between populations, EBM comparisons are extremely useful; for example, a 2006 report from the National Committee for Quality Assurance (NCQA) found significantly lower compliance with EBM diabetes care measures for Medicaid patients when compared to commercial and Medicare populations.

By layering this information with other socio-demographic data, rural/urban classification and zip-code analysis, it is possible to identify, localize and segment risk drivers – a key step in designing intelligent programs that improve health outcomes and proactively manage risks.

Figure 4.2: Predictive Analytics Drill-Down to Identify Leading Risk Factors



REAL WORLD APPLICATION

North Carolina's PBM: The value of understanding risk drivers for sensible cost containment strategies

From 1998 to 2000, state expenditures on pharmacy benefits soared by 66 percent in fiscal costs and a 57 percent increase in expenditures per user. To manage these costs, North Carolina Enhanced Pharmacy Program was implemented in 2002. It is a pharmacy benefit management (PBM) program and requires prior authorization for certain drugs prescribed to recipients. It also includes tighter controls, such as requiring recipients with eight or more current prescriptions to use a single pharmacist and undergo clinical reviews. It also limits episodic medicines (e.g. sleeping aids) because frequent utilization could indicate dependency or a more serious underlying condition. These measures are based on evidence-based medical guidelines and Food & Drug Administration (FDA) labeling. Another approach being taken is Carolina Access – a primary care case management (PCCM) program that began in 1991. The program links recipients with primary care providers, who act as healthcare gatekeepers. To improve healthcare outcomes, the state began paying providers $1 per-member-per-month (PMPM) in April 2003 for delivering care management services to Medicaid recipients enrolled in their practice.

Carolina Access laid the foundation for ACCESS II and III – enhanced primary care programs implemented in 1998 that bring together providers, hospitals, health departments, social services and other community resources to manage recipients' healthcare needs. ACCESS II and III (Community Care of North Carolina) include 14 networks with more than 3,000 providers managing nearly 800,000 Medicaid recipients across the state. In addition to a primary care provider, ACCESS II and III enrollees have care managers that assist in developing, implementing and evaluating enhanced managed care strategies at each site. ACCESS II and III providers receive $2.50 PMPM, and the demonstration sites are paid an additional $2.50 PMPM care management fee. As a result of these initiatives, North Carolina's Medicaid expenditures for fiscal year 2005-2006 grew less than 4 percent over the previous year, whereas in the previous two years spending grew 10.3 and 12.1 percent, respectively.

Policy Takeaways: Risk Management

- **Develop a comprehensive risk scorecard.** With an up-to-date snapshot of the risk drivers and health status for a population and its sub-groups, prioritizing Medicaid-related strategies becomes easier and more effective. Scorecard metrics should be regularly updated based on all available medical/healthcare data to paint a full and accurate picture of a state's Medicaid program. Such a 360-degree view can chart long-term trends and identify emerging problems early on.
- **Leverage metrics to drive improvements.** Over time, risk scores can show which interventions and incentives are successful – and which fail to produce desired results. Healthcare spending and resources can then be reallocated to maximize impact and minimize inefficiency.

Step 2: Align Plan and Program Design with Strategy.

Many state Medicaid programs have well-articulated missions, goals and strategies. But somewhere between strategic intent and program implementation, a breakdown occurs. The culprit is usually a combination of misaligned coverage and obsolete program designs. As any Medicaid administrator can attest, program design often lags behind strategy, sometimes by years. Program design is often kept in a rigid box by political, financial and regulatory issues. The literature of public health policy is rich with simplistic debate framed by those who wish to protect or extend a particular benefit, versus those who advocate otherwise, a banal distributive exercise. Meanwhile, illogical and costly inconsistencies persist within many Medicaid programs. For example, treatment for expensive complications that can arise from diabetes may be covered while the preventive services that might help a recipient properly manage their primary condition are not. Equally challenging, many of the best cost-containment strategies used in the private sector are outside of the regulatory framework of Medicaid programs as they exist today.

Vermont's Global Commitment to Health Waiver provides an excellent example of how one state confronted this issue – trading federal funding caps on acute care spending to reallocate funds into preventive measures not traditionally covered by Medicaid.

Transformation becomes possible, however, when critical health and financial risk information drives decision making. Practically speaking, the challenge is how to provide care to the current Medicaid population, while systematically eliminating the drivers of health and financial risk in likely future covered generations.

Medicaid population segments are diverse and have different health risks. Therefore, states need to categorize recipients based on common risk drivers and prioritize these categories in the same way that marketers target consumer segments. While composition of segments will vary from state-to-state, the Pareto principle still applies: it is likely that 80 percent of the health

REAL WORLD APPLICATION

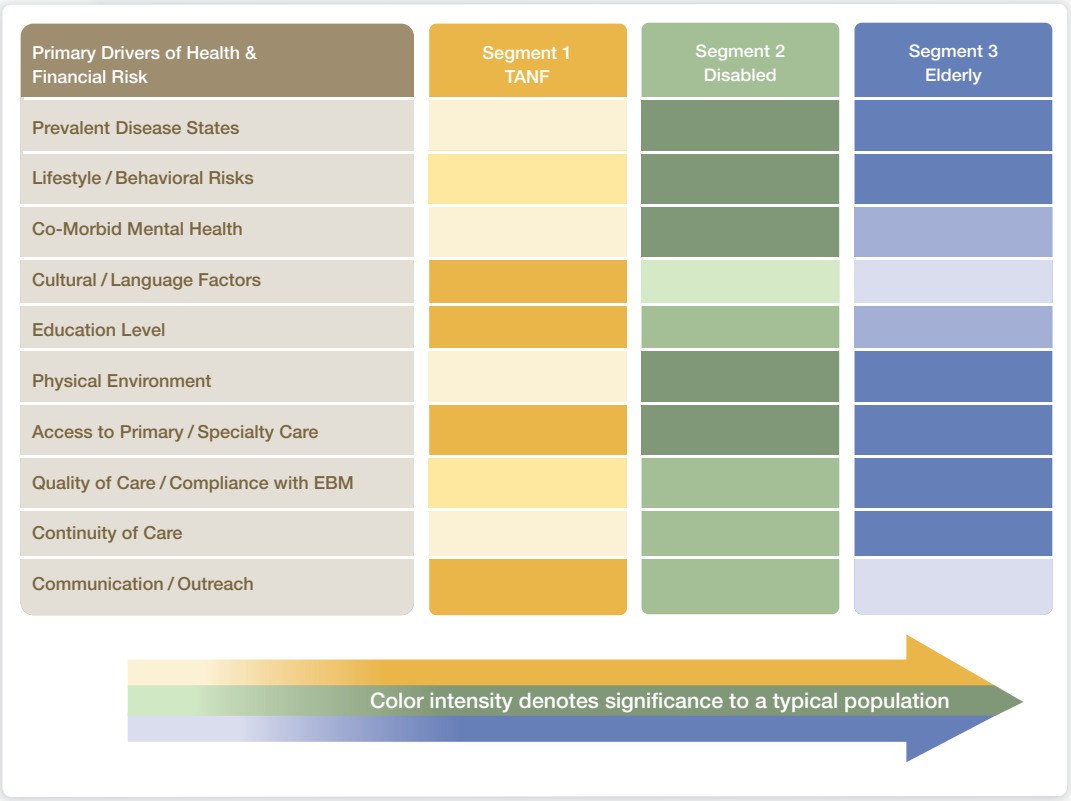
Vermont's Global Commitment to Health Waiver: Statewide benefits through Medicaid

In late 2005, Vermont secured CMS approval for its "Global Commitment waiver" that caps the amount the federal government provides for the state's Medicaid acute care services. Vermont's 2006 budget changed the Office for Vermont Health Access (OVHA) from a primary care case management (PCCM) model into a public managed care organization (MCO), which the state contracts with to serve its Medicaid population.

For taking on this financial risk, Vermont can use federal Medicaid funds to pay for some of its non-Medicaid health programs, such as respite care, smoking cessation, substance abuse, emergency mental health and newborn screenings. It also has additional flexibility in benefit designs, cost-sharing arrangements and enrollment rules.

The state has articulated that the goals of the waiver are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public healthcare coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation by focusing on healthcare outcomes.

Figure 4.3: Illustrative Segmentation of the Medicaid Population by Need and Risk



and financial risk drivers of a Medicaid population within any state can be effectively characterized by a limited number of well-defined segments. States will vary greatly in how they choose to define their segments, but the thought process is similar.

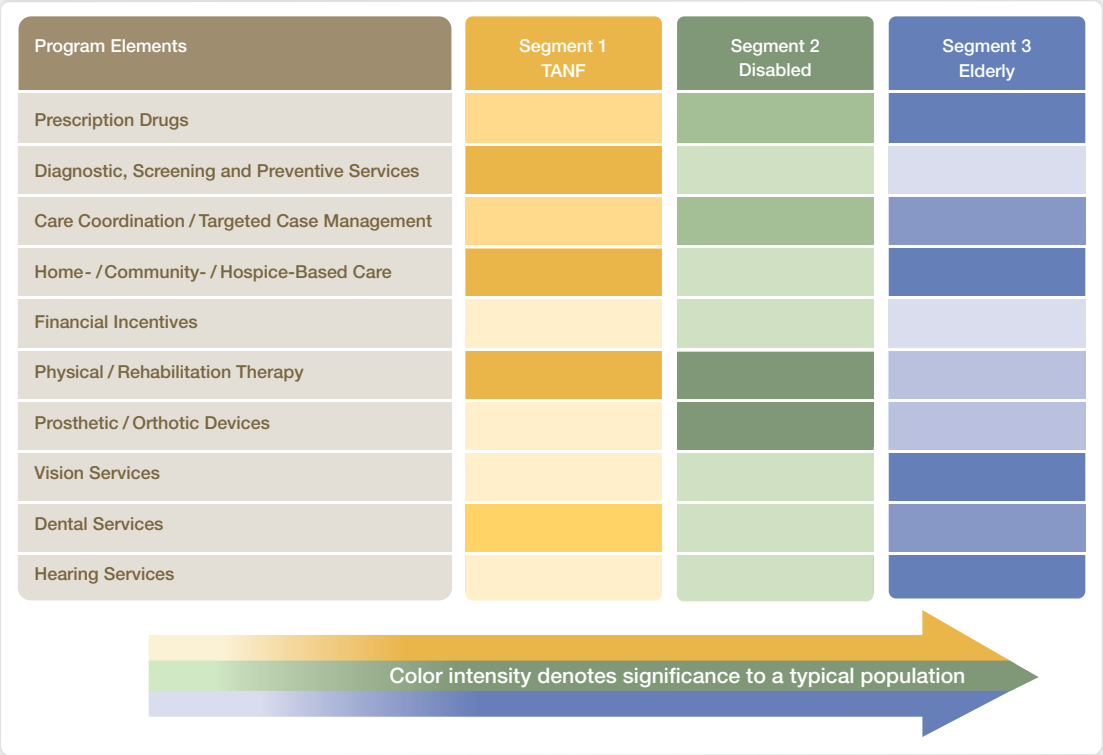
Figure 4.3 illustrates, prioritizing the targeted risks of each population segment can maximize program impact. The most prevalent, and costly, risks (typically those associated with higher incidence of acute care) are addressed first to ensure immediate health and financial impact within each segment. A segmented approach also creates more responsive person-centric programs designed to meet the special needs of specific populations and the challenges they face.

This analysis quickly concludes that a one-size-fits-all approach to program design is not effective. While it is not practical to develop a customized program design for every recipient, it is possible to design plans that meet the health and social needs of the population segments. Once these segments are identified, coverage, incentives, care management, personal empowerment and ancillary social services can be designed to eliminate risk. As a result, program design is transformed from a distributive exercise to a value creation exercise.

When developing program design, many elements should be considered including:

- Utilization management oversight (precertification, concurrent review, discharge planning);
- Health advocacy and shared decision support;
- Disease and case management programs (physician collaboration, care coordination, behavioral change techniques);
- Benefit plan architectures that leverage the right mix of consumerism tools and financial assistance; and
- Ancillary social assistance to eliminate barriers to care.

Figure 4.4: Customized Program Designs to Meet the Needs of Distinct Medicaid Segments



Policy Takeaways: Program Design

- **Heed risk drivers.** Each state has unique healthcare issues and disease prevalence. By effectively measuring these risk drivers and their associated costs (as outlined in the previous step), program designs can zero-in on the greatest healthcare barriers, such as compliance, quality, utilization and access, and then implement targeted solutions to overcome them.
- **Offer incentives to achieve desired results.** Studies show that the "carrot" is often more effective than the "stick." Designing an attractive, yet cost-effective, incentive program can produce improved outcomes – and increased savings in the long-run. Incentive models can: a) encourage recipients to change unhealthy behaviors, follow preventive medicine and engage in care management programs; and b) reward providers that deliver superior care and promote evidence-based medicine via pay-for-performance programs. While the options are nearly limitless, a growing field of study has identified incentive-related best practices that states should consult during the design phase.
- **Address social barriers to care and health management.** Again, these barriers will vary from state-to-state. Common issues include transportation difficulties, unavailable or inaccessible information, little-or-no care coordination and mental health complications. Effective Medicaid programs must identify such barriers, overcome them – and continually monitor recipients for new or unmet needs.

The overarching goal is to design benefit plans that optimize the value of services recipients receive, encourage personal responsibility and healthy behaviors and lower Medicaid costs. However, it is important to recognize that prudent investments today can result in significant future savings.

Finally, because individual plans are designed to be consistent with identified metrics, there is complete transparency between overall financial metrics, risk drivers and individual program performance by segment. Clear metrics allow states to measure the effectiveness of their programs on targeted populations or risk factors – and adjust accordingly. If the programs are effective, better health outcomes and lower risk scores across the entire population can be expected. Accountability and gradual improvements are cures to bureaucratic inertia and consistently poor performance results.

REAL WORLD APPLICATION

Customization in Kentucky: Choice, encouragement and empowerment

"Kentucky has regions with very high incidents of obesity and diabetes. We need to target those populations differently, and have the flexibility to customize Medicaid to meet the needs of the population and the geographic areas within the confines of our own state. We spent two years building the infrastructure and securing the services of a pharmacy benefits administrator to appropriately manage our pharmaceutical costs, while still allowing the state to retain decision-making authority. We focused on getting the computer systems and data warehousing capability updated so that we have the right decision support tools to help us manage the population. Then we secured additional clinical expertise in the form of medical directors, pharmacy directors and nurse case managers, either in-house or through contractual arrangements. Since we have the infrastructure and decision support systems in place, we're able to identify opportunities to improve care through disease management within the population. By targeting individuals who visited the emergency room more than five times a year, and directing them to a more appropriate care setting, we can improve the quality of care and simultaneously achieve cost savings."

"So we made significant progress in putting the 'three legs of Medicaid modernization' in place: improved technology, care management and benefit management. Another component that is evolving under our new flexibility guidelines, as a result of the Deficit Reduction Act, is placing the entire Medicaid population into one of four benefit plans: global choices, family choices, optimum choices or comprehensive choices, depending on how they access Medicaid eligibility. These plans are tailored to the needs of healthy people, as well as those with disabilities and those in need for long-term care. The different benefit plans are designed to meet the unique needs of each population."

"We've put into place a platform that can be improved incrementally over time as Medicaid enrollees become more enlightened to the fact they have a benefit plan. They have a schedule of benefits just like individuals in the commercial market. There is a service limit and there are variable co-pays. This concept engages the recipient and that's one of the things we've strived for – getting the recipient more involved in making healthcare decisions. Under typical Medicaid, it was an open-ended entitlement. In this model, people can be more appropriate stewards of their healthcare benefits and hopefully, as a result, will make more informed decisions."

– Mark D. Birdwhistell, Secretary, Kentucky's Cabinet for Health and Family Services

Step 3: Design a Person-Centric Delivery Model.

Better health is achieved one patient at a time. "Treatment" rendered in a doctor's office is only a small part of the etiology of healing. Estimates show that the typical doctor-patient interaction averages no more than eight minutes. It is what happens after the individual leaves the doctor's office that is most important, especially in the management of chronic diseases and recovery from catastrophic illness. Traditional healthcare coverage leaves unmet needs that continue to drive poor health and higher costs. Does the individual have co-morbid conditions? Do they lack critical information for self-care? Do they need access to special equipment? Do they have access to the right provider? Can their caregivers accurately recount their systems and history to their provider? And when they arrive to see a specialist, are they required to recount their medical history yet one more time (often with critical omissions)?

A person-centric healthcare delivery model considers these non-traditional factors to treat individuals and assist them in achieving the best possible health outcome. It employs new technologies, plan design and delivery models to treat the whole person.

An intelligent, technology-enabled, person-centric approach to the delivery of healthcare makes sense for all Americans; but it is especially apropos for Medicaid populations, where more than 61 percent of adult recipients have at least one chronic disease. Poverty creates a diverse and confounding range of barriers to achieving health, any one of which can drive high healthcare costs. Figure 4.5 on page 55 highlights several of these barriers.

A key first step in developing a person-centric model is identifying and quantifying specific, localized needs that cannot be addressed except as a campaign or on an individual basis – and then prioritize them by impact. With properly designed metrics, health risk scores can drill down to assess small groups and identify priorities for serving them.

Once these groups have been identified, there must be sufficient creativity and flexibility to propose and deliver specific solutions. Interestingly, the most cost-effective solutions are also those most likely to help individuals with their lives. What might such interventions look like? Here are three examples:

- Scenario A) **Spanish-speaking members utilize ERs for non-emergencies twice as often as English-speaking members.** *Targeted solution:* Launch a concerted multilingual campaign leveraging multiple mediums to encourage urgent care utilization or, better yet, standard provider visits for non-life threatening healthcare needs.

- Scenario B) **A higher percentage of low-income elderly miss appointments with their doctors due to lack of transportation.**
  Targeted solution: Provide reimbursement or sign brokerage agreements for non-emergency transportation to healthcare providers.

- Scenario C) **Rural diabetics are three times less likely to receive foot exams.**
  Targeted solution: Leverage telemedicine to offer podiatry consults for rural physicians and their patients – opening access to a specialty unavailable locally and lowering the incidence of diabetes-related complications, such as neuropathy and amputations.

Each scenario highlights creative methods of overcoming unique difficulties in delivering healthcare services to a targeted population – or a single recipient. However, they illustrate that once identified, *inadequate care can be corrected through targeted solutions.* Meeting such unique needs is pivotal to Medicaid transformation.

While it's easy to propose common-sense solutions to specific challenges, in practice it can be very difficult to *implement these solutions as standard operating procedure on a massive scale.* Many social service programs are run by separate departments with separate funding, separate goals and objectives and technology platforms that don't even talk to one another. Moreover, the regulatory environment may not support the needed flexibility. Recordkeeping alone could drown a case management process that touches several separate administrative departments.

The ideal Medicaid delivery mechanism would reorganize regulations and service delivery in such a way that addressing unique needs would be the norm rather than an exception – while allowing appropriate oversight and quality control. It would broaden Medicaid to manage health risks not traditionally covered and permit a continual evolution in specific interventions without requiring new legislation or regulation. Person-centric delivery requires several critical factors for success:

- **An overarching delivery model:** There needs to be a model for overall coordination of care that integrates:
  - All care management services, including utilization review, 24-hour nurse line, disease management and case management, as a single program.
  - High-quality primary care and specialty providers – so the provider becomes *part of the team.*
  - Ancillary social service programs for health education, transportation, SCHIP, mental health, community health and wellness.
- **Prioritization to maximize health and financial impact:** Health metrics need to be continuously updated with new claims, biometric information and pharmaceutical data to target populations and trigger interventions accordingly.
- **Technology that supports integrated delivery:** The entire technological framework must support a case management approach to recipients by:
  - Providing a complete view of recipients, including an electronic personal health record, along with case and social information that impact health risk;
  - Protecting personal privacy and dignity, as specified by HIPAA; and
  - Providing the entire care team with records of all recipient interactions via a single, automated system.
- **Clear roles and responsibilities:** The recipient's care team will likely include state employees as well as third-party vendors and providers. The entire team must be organized so that addressing unique needs is a standard operating procedure.
- **Linked incentives:** Financial incentives used with recipients or providers cannot be treated separately from other components.

- **Flexible regulatory environment:** To ensure optimal treatment, regulation must be reconfigured to permit discretionary spending either by the recipient or their care team on the patient's behalf.

A strong case can be made for each of these success factors on a standalone basis. For example, an electronic health record can save lives; however, in order to be most effective, all of the pieces need to work together. Some states have adopted an innovative mindset but continue to design, purchase and deliver services cafeteria-style, and organize their Medicaid programs into compartments that don't work well together.

Before strategies for Medicaid technology and care management services can evolve, states need to approach the drawing board with this end-goal in mind: *create an intelligent, person-centric delivery model that permits teamwork, streamlines recordkeeping and supports interventions that achieve better health outcomes at lower cost.* Real innovation begins with an overall delivery framework that drives decisions around technology, care management, vendor selection, incentive design and regulatory reform.

REAL WORLD APPLICATION

Cash and Counseling Demonstration in Idaho: Targeted approaches

Idaho has moved toward managing the elderly, disabled and healthy differently – because each group has unique needs. The state is also incorporating elements of a consumer-centric model into its Medicaid program. It has adopted the national cash and counseling demonstration model and by 2007, nearly 25,000 recipients will be eligible for preventive health benefits if they show a desire to change unhealthy habits (e.g. quit smoking, lose weight).

Cash and counseling demonstrations are consumer-centric models that provide fiscal assistance and supportive services to disabled Medicaid populations. Eligible recipients receive a flexible monthly stipend to purchase disability-related services, such as hiring caregivers (including relatives). It also allows recipients to bestow decision-making power on their behalf to family members or other representatives. These demonstrations are clearly applicable to Medicaid recipients of any age and with any sort of cognitive or physical disability. The 2005 Deficit Reduction Act provided states with the ability to offer home- and community-based services and self-directed personal assistance services as part of their Medicaid programs without applying for a waiver from CMS.

Policy Takeaways: Integrated Delivery

- **Assess all available delivery options.** Managed care, specialty networks for chronic condition management, consumer-based incentives – states can approach Medicaid delivery in different ways. Assessing each one based upon its viability, financial ramifications and appropriateness allows states to craft flexible delivery systems for populations or sub-segments.
- **Ensure unique needs are met.** By charting the risk profile of each population segment, states can prioritize the most-needed services and monitor the effective delivery of these services. Other delivery barriers inherent in Medicaid, such as churning, communication difficulties and trust issues, also require concerted action to overcome them.
- **Chart overlaps in recipient services across state agencies.** "Integration teams" comprising authority figures from each agency can then eliminate duplication and facilitate seamless delivery.

Figure 4.5: Barriers to Quality, Cost-Effective Healthcare in the Medicaid Environment

Characteristic	Description	Challenge	Solution
Unhealthy Lifestyles	Recipients often have poor health behaviors that are catalysts for chronic and catastrophic health conditions, and lack awareness and education on how to change.	Poverty creates barriers to healthy lifestyles. Smoking alone results in $12.9 billion Medicaid-related costs each year.	Targeted care coordination activities and incentives can drive desired outcomes based on prevalent health risks and conditions.
Low Education Level	Low education level directly correlates with the unhealthy behaviors driving poor health and costly conditions.	Concerted efforts are needed to create meaningful and relevant communications.	Printed forms, education materials and provider instructions must be written at a 4th grade reading level.
Co-Morbidities	Co-morbidities drive higher pharmacy costs, outpatient visits and hospital admissions – sometimes four times greater than other recipients.	Rather than focus on a single healthcare event or condition, more comprehensive care is needed to treat the entire disease history.	Educate recipients about daily self-care, empowering them to follow prescribed treatments and take good care of their conditions.
Provider Interaction	Providers have little or no experience treating patients with cultural differences (e.g. traditional medicine or working through a translator). Time constraints limit careful explanations of conditions and treatment plans.	Recipients feel rushed and confused – so they are more likely to distrust diagnoses, incorrectly follow treatment plans and ignore recommended lifestyle changes.	Educate providers on culturally-competent healthcare. Advance health literacy. Develop multi-lingual materials for local/regional areas.
Access to Care	Providers are wary of accepting Medicaid patients due to low reimbursement rates, high administrative costs and frustrating changes in program requirements.	Recipients are less likely to receive preventive care, follow evidence-based medicine, understand treatment plans and make lifestyle improvements. Without a primary care provider, the emergency room becomes the doctor's office.	Appropriate redirection of care based on severity – without denying or dissuading treatment.
Churning	Loss of healthcare coverage and then regained after a short time period. It can be caused by renewal difficulties, transition across public assistance programs and imposed premiums.	Churning bounces recipients from doctor to doctor, interrupting continuity of care. It also wastes time and spending for all parties involved.	Streamline renewal processes by reducing frequency and automating requests when data is available. Electronic medical records can minimize the effects of changing providers on care continuity.
Fragmentation	Services outside of state governments' purview are managed in silos, making today's healthcare duplicative, inefficient and costly.	Recipients are often unaware of available assistance or cannot access it due to lack of transportation, childcare or workplace flexibility.	Integrate structures, services and incentives. Frequently communicate available programs and initiatives.
Contact Information	Recipients can be difficult to reach due to churning, verification problems and frequent moves/lack of home ownership.	Providers face difficulties in maintaining accurate, up-to-date medical records on transitory patients.	Community resources can act as information "hubs" on Medicaid programs, education and awareness.
Lack of Trust	Recipients may feel their provider is purely motivated by government compensation and see them as "welfare cases" rather than "true" patients.	Recipients may lack the tools and information needed to locate high-quality participating providers.	Additional counseling and outreach helps recipients navigate the healthcare system.

Step 4: Implement Advanced Technology.

Perhaps in no other field has technology transformed our lives more than medicine and healthcare delivery. Technology opens the door to longer – and better – lives than any generation before. The challenge is turning *today's* potential into *tomorrow's* real-world applications that garner widespread adoption.

Health information technology (HIT) plays a key role in transforming Medicaid by streamlining administrative processes, eliminating duplicative services and improving health outcomes. In addition to improving efficiency and accuracy, the use of "intelligent technologies" can help manage Medicaid costs. These technologies extend beyond administrative functions and can include decision-support tools, informatics and data warehousing. These tools provide states with a clear picture of how much they are spending, where they are spending it, and when to refer certain groups – such as the chronically ill – to disease or case management programs. Such valuable information is incredibly useful for crafting and tailoring a state's Medicaid program. HIT can improve the quality, safety and efficiency of healthcare services provided through Medicaid. According to the report *Achieving Electronic Connectivity in Healthcare* published by the Markle and Robert Wood Johnson foundations:

- Missed opportunities for healthcare prevention or timely intervention results in more than $1 billion in avoidable hospital costs annually;
- Fifty-seven percent of patients must recount the same medical history or other personal health information to multiple health professionals;
- Providers offer conflicting information to 26 percent of patients;
- Twenty-two percent of patients have duplicative tests ordered by different providers;
- Test results fail to reach providers' offices in time for patient appointments 25 percent of the time; and
- One-third of all U.S. healthcare costs go to duplicative care that does not improve patient health.

While not a cure-all, HIT applications can improve these statistics. Figure 4.6 lists some examples of HIT and their benefits for recipients, providers and states.

Yet with Medicaid, there are challenges to adapting HIT:

- **For recipients:** Many have little or no access or trust in key healthcare technologies, such as the Internet. Economic limitations, geographic location, age and disability are limiting factors. However, technology is highly-versatile, configurable and innovative. Targeted applications can revolutionize how recipients receive healthcare and manage their health.

Railroads were built in this country in the middle of the 1800s. They had one dilemma in being able to connect all the railroads that were being built: the rail gauges did not line up.

We obviously have the same problem in healthcare. I go to many large communities where I will see multiple hospitals. Multiple hospitals will be spending tens of millions of dollars on health IT, but they won't be on the same system. They won't even be compatible systems. So the first requirement for the development of value-based [healthcare] competition is connecting the rail gauges. The systems have to be compatible.

–Michael Leavitt, Secretary, U.S. Department of Health and Human Services
Remarks Delivered on September 26, 2006

Figure 4.6: Key Health Information Technology Applications

HIT	What it Does	Recipient Benefits	Provider/State Benefits
Computerized Physician Order Entry (e-prescribing)	Using an automated data entry system to prescribe medications electronically (via PC, handheld or other device) rather than relying on handwritten prescriptions	• Reduce preventable prescription errors by 55 percent or more • Can prevent more than 2 million adverse drug reactions and 190,000 needless hospitalizations each year • Receive better care via evidence-based medical (EBM) guidelines • Track medication history over time • Improved compliance via refill notifications (i.e. providers alerted if medicines aren't filled as prescribed) • Save time by sending pharmacies e-prescriptions	• Greater safety and accuracy by eliminating legibility issues and showing drug allergies/interactions • Potential discounts on malpractice insurance • More efficient (e.g. fewer pharmacy call-backs) • Displays formulary menus, alternate medicines, default dosages and patient-specific information (e.g. lab values) onscreen • Finds comparable medicines that are less expensive • Ensures treatment follows EBM guidelines • Promises $2.7 billion in yearly Medicaid savings alone
Electronic Medical Health Records	Up-to-date patient medical information from multiple sources, which assists with quality improvement, outcome reporting, resource management and public health surveillance	• Bypass need to provide medical histories at each visit with a new provider or remember information relayed by other specialists • Ensures all providers are on the same page, improving care and reducing the risk of medication interactions, duplicative tests and confusion • Portability eliminates hassles with changing providers or visiting outside specialists	• Improve efficiency and maximize patient face-to-face time by eliminating the need to chronicle medical history/updates • Provide better care and more accurate diagnoses by incorporating findings, lab data, etc. from other providers • Prevent fraud and medication abuse • Easier, more accessible record-keeping for improved data management, auditing and other administrative functions
Telemedicine	Telemedicine is the use of audio, video and other telecom/electronic information processing technologies to provide health services or assist healthcare personnel at distant sites	• Receive higher-quality care from providers, specialists or mental health professionals unavailable in the recipient's local area – particularly for those with transportation barriers (e.g. distance or disabilities) • Eases delays and frustrations from limited or overstretched Medicaid providers • Strengthens partnerships and teamwork approaches to healthcare • Greater communication with providers leads to active engagement in health and healthcare decisions	• Alleviates some of the burden from provider shortages • Allows providers to collaborate, share information and find creative solutions • CMS reports at least 18 states allow some form of Medicaid reimbursement for telemedicine • States have flexibility in setup to meet unique needs/goals • Cost-effective way to reduce access barriers
Personal Health Accounts (Spending Accounts)	Allocates funds for recipients to "purchase" private insurance or benefits; additional funds can be allocated as incentives for healthy behaviors, preventive care and participation in care management programs	• Freedom to choose health coverage most appropriate for the recipient's unique needs and health status • Rewards healthy lifestyles and engagement in key health improvement activities • Moves from a culture of dependency to greater health empowerment and control • Potential for portability irrespective of changes in eligibility or employment (i.e. doesn't penalize for exiting Medicaid)	• Less administrative and bureaucratic hassles for reimbursement • Outside incentives for compliance/adoption of recommended or prescribed healthy behaviors • Achieve market-competitive rates for healthcare services
Decision Support (Multiple Mediums)	Provide vital healthcare information to help make the best decisions; spans the spectrum from health-related definitions and news, to provider/hospital ratings and pricing information, through assistance with choosing health plans	• Learn about health issues and conditions, empowering greater self-care and self-management • Assistance with Medicaid decisions (e.g. managed care plan enrollment, renewal, eligibility)	• More informed and engaged patients that are likely to follow prescribed treatments and take an active role in managing their health • Opportunity for influx of new patients for accomplished providers • Easier renewal process reduces churning of Medicaid patients in and out of practice
Health Partnerships	Stronger links between payers, providers, recipients, advocates and community groups – including easier referrals for needed care/programs, greater flows of information, better continuity of care and comprehensive care/case management	• Empowers recipients to take greater control of their health • Offers and resources and support that may otherwise be unavailable or too complicated to coordinate • Social network and/or safety net for such a vulnerable population • Engages community in taking an active interest in promoting a culture of health and working hand-in-hand with Medicaid programs	• Reduces patient depression and/or isolation • Expands healthcare "team" supporting patients that often have complex/multiple health problems • Fosters greater healthcare engagement and competence • Alleviates some of the workload associated with care/case management activities and coordinating available social services
Tracking Quality Metrics	Provides states, providers and recipients with performance, compliance and satisfaction data	• Measures care against evidence-based medical guidelines • Access to "report cards" on hospitals, providers and Medicaid managed care plans to comparison shop	• Pay-for-performance rewards providers for delivering high-quality healthcare that follows EBM guidelines • States can utilize HEDIS, CAHPS and NCQA data when choosing/renewing Medicaid provider contracts

- **For providers:** Financial constraints or geographic location may hinder their ability to purchase and maintain equipment. Providers and their staff often are not confident in their ability to operate new equipment – or resist moving beyond the paper-based system they've always known. Yet innovative uses of HIT can help provide better care for patients and streamline the time it takes to deliver care.
- **For states:** Building a technology infrastructure to support Medicaid programs can be expensive and time-consuming. Once in place, infrastructure requires a highly specialized staff to perform ongoing repairs, maintenance and upgrades. Despite the hurdles, a flexible HIT system can significantly improve recipients' health outcomes and reduce the state's fiscal burden.

Technology holds great promise in transforming Medicaid for recipients, providers and state sponsors. Yet as states integrate HIT into their Medicaid programs, many are building isolated or "siloed" technology infrastructures to support these projects. For those looking to streamline and improve operations, this trend is problematic.

As states lay the foundations of their technology infrastructure, what impact do varying platforms have on Medicaid? *Disconnects* are the biggest dangers. If divergent silos cannot interact with electronic health records, claims data and other sources of healthcare information – gains made in efficiency, effectiveness and safety would be significantly diluted or eliminated entirely.

Ideally, a single HIT infrastructure would link each state together. Such a unified platform would uphold accepted standards, allow for nationwide measurements / research impossible today and increase efficiencies. Best of all, HIT-related innovations or improvements discovered by one state could be applied to other states as well.

Administrative functions automated by Medicaid Management Information Systems (MMIS) determine how efficiently, accurately and cost-effectively Medicaid programs confirm eligibility, pay claims and reimburse providers. Such specialized data management has led two-thirds of states to outsource MMIS. As the engine that runs Medicaid, MMIS must be flexible enough to communicate with outside platforms – especially with the growing emphasis on electronic healthcare services. To foster this interoperability, CMS' Medicaid Information Technology Architecture (MITA) initiative seeks to standardize and codify a "best-in-class" MMIS architecture that can be applied nationwide.

HIT also plays a *qualitative* role. Tools directed at recipients, providers and / or states promise quality improvements, increased safety and greater accountability. While there are challenges in leveraging such tools in the Medicaid environment (financing, widespread adoption, protecting health information), the benefits to stakeholders outweigh the costs and frustrations inherent in such change.

Medicaid systems are packed with valuable information and patterns about consumption, services, outcomes, treatment regimens and prescription drugs … [that need] to be transformed into information to empower the healthcare system. By incorporating evidence-based decision support and predictive modeling technology, states can turn existing claims paying data into information that tells a story about a patient and gives providers a way to use it. Imagine if states developed web-based information portals where providers could easily determine who their sickest patients are, by name and disease, not just the total number of them? What if states enabled providers to use predictive modeling to help them understand who their sickest patients will be without intervention? With 25 percent of the Medicaid population consuming 70 percent of the budget, everyone involved could act more efficiently for top-to-bottom benefits.

Source: Greenstein, Bruce. "Reforming Medicaid: Data needs to become accessible information." Managed Healthcare Executive. July 1, 2006.

REAL WORLD APPLICATION

Health information technology in Georgia: Discovering best practices and promoting transparency

In 2005, Georgia Governor Sonny Perdue submitted a plan to modernize Georgia's Medicaid program in which healthcare transparency was a critical component. In October 2006, Governor Perdue established the Health Information Technology and Transparency Advisory Board. The board is charged with encouraging widespread adoption of electronic medical records and developing a statewide strategy for the clear and timely exchange of healthcare-related information.

According to Dr. Rhonda Medows, commissioner of Georgia's Department of Community Health, "Communication in healthcare is essential for success. Our goals for HIT are simple: understandable, universal, timely and secure communication of health information across the public and private sectors for the benefit of today's healthcare consumer. Let's build bridges – not barriers."

In its inaugural meeting, the board viewed presentations from regional HIT experts. Holt Anderson, with the North Carolina Healthcare Information and Communication Alliance, offered this advice: "Focus on clear drivers: quality of care and effect on cost; complex and costly chronic conditions; physician workflow to save time and improve job satisfaction (medication history, allergies, problem lists); and build on quick wins with obvious benefits to the public."

Lisa Rawlins, bureau chief of the Florida Center for Health Information and Policy Analysis, illustrated several transparency initiatives in her state. The first, www.MyFloridaRx.com, compares retail prescription drug prices; www.FloridaCompareCare.gov evaluates hospitals and ambulatory surgery centers (ASC); and health plan- and physician-based web tools are in the works. What is the demand for such information? On its go-live date, FloridaCompareCare.gov received 70,000 hits – without any major marketing push.

Georgia's experience highlights several key points in adopting HIT to Medicaid: seek out best practices; collaborate with neighboring states and third-party experts; and provide the tools needed to make wise healthcare decisions. As U.S. Health and Human Services Secretary Michael Leavitt said of this initiative, "The cornerstones of a better healthcare system are electronic health records, more information on the cost and quality of care, and incentives that reward high quality at low costs."

Policy Takeaways: Technology

- **Leverage HIT to close gaps in care.** Some applications are useful for any American, such as electronic medical records. Others, like telemedicine, may be more relevant in states with large rural populations. The goal is applying the right tools, in the right way, to increase access, improve the quality of care and increase safety.
- **Encourage HIT adoption.** Once HIT is incorporated, fostering widespread use among providers and recipients can require special outreach, education and assistance.
- **Break down disconnected silos.** Links between technology platforms are essential for integrated delivery and streamlined operations. Increasingly, CMS and other thought leaders are working to establish standards for HIT applications and MMIS architecture. As states collaborate with these groups and adopt accepted practices, a unified technology infrastructure will allow them to share research, increase efficiencies and improve performance.

Step 5: Coordinate Care.

Care management is a proven method of reducing healthcare costs and unnecessary utilization. For example, health data from one state shows that nearly two-thirds of its Medicaid population have at least one of five chronic diseases (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and diabetes).

Because disease prevalence inevitably varies from state-to-state, each should evaluate its unique risks and create programs targeting their high-cost, high-prevalence conditions. Figure 4.7 categorizes common approaches to care management.

Many states lack the technical capabilities, medical expertise or financial resources needed to design, implement and monitor such programs on their own. However, several states have experienced success with their unique approaches to care management – often through partnerships with healthcare vendors.

Between 2002 and 2005, 42 states began, or planned to begin, Medicaid disease management and case management programs. Figure 4.8 on page 63 highlights notable examples. Figure 4.9 on page 64 shows our suggested checklist for designing, operating and improving care management programs. These programs must provide more than expanded case management services; they should address the personal and social challenges common to Medicaid populations, adequately serve the needs of these populations and become advocates for comprehensive care that extends beyond the provider's office – and into areas such as treatment centers, rehabilitation clinics and housing assistance. This coordination requires buy-in from many stakeholders, including state agencies, legislatures and governors, recipients, caregivers, providers and healthcare delivery organizations.

	Care Management				
	Disease Management	Case Management	Utilization Management	Nurse Line	Wellness
Definition	System of coordinated healthcare interventions and communications for conditions in which self-care is significant	Collaborative assessment. planning, facilitation and advocacy to meet health needs via communication and available resources	Process of evaluating the necessity, efficiency and appropriateness of healthcare services	Immediate clinical support for day-to-day health issues and early detection of medical emergencies	Promotion or maintenance of optimal health
Objective	Empower and educate participants utilizing evidence-based medicine compliance to improve management of chronic conditions	Promote quality, cost-effective outcomes during and after major health events	Ensure provided care is medically necessary, performed in appropriate settings and meets established guidelines	24/7 demand management (i.e. guide individuals to seek the right level of care)	Encourage behaviors that prolong and enhance one's overall health status, quality of life and lifespan
Target Population	Those with chronic conditions, such as heart diseases, lung problems and diabetes	Those facing acute or extraordinary health crises (e.g. trauma, HIV/AIDS, multiple sclerosis)	High-cost and high-utilization individuals	Useful for entire population	Beneficial for entire population – especially those at-risk
Services	Education; individual care plans; nurse counseling	Nurse counseling; care coordination; fee negotiation	Pre-certification/prior authorization; prospective/concurrent/ retrospective reviews; discharge planning	Decision support; health advocacy and information	Health risk assessments; health coaching; screenings; management programs (e.g. smoking cessation, weight, stress, pregnancy)

Figure 4.7: Care Management Matrix

INSIGHT

The role of community care in Medicaid

North Carolina's Medicaid program is very different from most states. Through our Community Care of North Carolina (CCNC) program, we've developed 15 statewide networks led by primary care physicians (PCPs). Each one includes local hospitals and departments of social services, because health status is not simply a medical issue – especially for Medicaid populations. Public health departments are also pivotal, since many people in a rural state like ours access healthcare through their local health department. Our community care model initially covered mothers and children only; now, we're working to include our elderly and disabled recipients as well. In terms of access, urban and rural areas have community care networks that manage and deliver services to our Medicaid population. So, we can truly say that every non-elderly recipient in North Carolina has a medical home – and that's the goal. It's more sophisticated and enhanced than many traditional PCP programs.

As Medicaid administrator, the state holds these networks accountable to measurable outcomes around various conditions, such as asthma, diabetes and COPD. To institute healthcare best practices, the medical directors of each network meet monthly to adopt treatment protocols based on evidence-based medicine. Then, they pilot these protocols in various networks to ensure that they are not detrimental to physician workflows – and that they produce desired outcomes. Once everyone is comfortable, we mandate that all of the networks adopt them. Ongoing data monitoring evaluates how well the networks adhere to these protocols. For those that don't, there is a lot of peer-to-peer education and support to help boost compliance.

This integrated model has been shown to enhance recipient care, as well as save money for the Medicaid program. It's an excellent program, and we've garnered support from members of the state legislature for our approach.

While our Medicaid program works very well, there are, of course, problem areas. One, which I think is true of many Medicaid programs, is recipient access to dentists, mental health professionals and certain specialists. Another issue is demographics. In terms of ratio, North Carolina has one of the fastest-growing Latino populations in the country. This influx has placed enormous stress on public health departments and hospitals, primarily. It's caught up in the current immigration debate, so it's politically-charged. Disparities are also problematic; we see them between minority groups, as well as between geographic locations. And finally, there's always the uninsured and how to meet their healthcare needs. North Carolina has been through an economic downturn, so we have a high rate of uninsured.

Looking toward the future, we see three overarching goals for North Carolina's Medicaid program: continuing to develop and enhance our community care networks; expanding upon the disease management initiatives that we have underway; and working to integrate mental health more closely into our networks and regional health systems.

Carmen Hooker Odom
North Carolina

Secretary, Department of Health and Human Services

"We can truly say that every non-elderly recipient in North Carolina has a medical home – and that's the goal."

Because Medicaid recipients often have special needs that transcend a specific health condition, the care management model most applicable is health advocacy. Health advocacy addresses one's strengths and vulnerabilities, and groups standard treatment protocols into a single care plan tailored to that individual's situation. Advocacy-based coordinators monitor and aid recipients as they progress toward specific, mutually-determined goals. This determination is based upon the various resources (personal, medical, behavioral, social, economic and community) needed to optimize their health status. The coordinator then engages these cross-functional resources to follow a single case plan and achieve shared goals. The advocacy model depends upon collaboration and planning through shared information and joint problem solving, rather than disconnected silos.

In practice, effective health advocacy requires:

- An integrated delivery model that is based on personal strengths;
- Processes, data flows and interactive technology that support cross-functional case management and seamless program delivery;
- The ability to track overarching outcomes and continuously improve interventions; and
- An organizational culture that values teamwork between all stakeholders to achieve desired outcomes for recipients.

Heath advocacy ensures recipients receive cultural, educational, social and economic assistance to effectively manage chronic conditions; receive care that complies with nationally-accepted standards; and engage in wellness or preventive activities that lower their risk of future illness or complications. Its common goal: appropriate, cost-effective healthcare decisions and improved health outcomes.

As the care management field evolves – and states' experience with delivering such programs in Medicaid environments deepens – we anticipate that "best practices" will emerge and gain widespread adoption. And as Medicaid populations become more costly and increasingly burdened with disabilities and / or chronic health conditions, one certainty exists: the importance of care management will not diminish.

Policy Takeaways: Care Management

- **Employ a personal advocate model.** This model permits coordination of personal, medical, behavioral, social service, economic and community resources as a single case plan.
- **Address the entire healthcare continuum.** Well, at-risk, chronic, catastrophic – each segment requires its own suite of interventions with intensity matched to risk.
- **Boost program results through incentives.** Rewarding recipients for enrolling in care management offerings spurs greater participation and more active engagement. Depending on a program's duration, tiered incentives increase the likelihood that participants will not disengage prematurely.
- **Communicate clearly and openly.** Communications should be culturally-sensitive, multilingual, understandable and easy to read. Multiple distribution channels increase outreach effectiveness and awareness.

Figure 4.8: Examples of State Care Management Initiatives

State	Program Name	Start Date	Program Design	Participants	Results
NC	Community Care of North Carolina (CCNC) [Formerly ACCESS II and III]	1998	Primary-Care Case Management • Partnerships with 15 community networks • Identifies and intervenes with patients; improves accountability	1.2 million	Asthmatics (2002) - $1.6 million annual savings - 21% fewer hospitalizations for children - 25% fewer hospitalizations for adults Diabetics (2002) - $306,432 annual savings - 9% fewer hospitalizations
CO, AR, KS, OK, WA	Advanced Care Management Task Force	2002	Advanced Care Management Research Effort • Cooperative research effort coordinated by CoverColorado (state's high-risk pool health plan) that assesses data in several states to measure the impact of care manage ment strategies on high-risk patients • Findings allow participating states to compare and manage costs and to learn about best practices	5-state collaboration effort	From 2002 to 2003, CoverColorado's care management program resulted in: • Hospital admissions per 1,000 declined from 192.3 to 137.8; • Bed days per 1,000 reduced from 968.2 to 543.0; • Average length of stays reduced from 5.0 to 3.9; • Average cost per inpatient day declined from $3,675 to $2,764, and • Cost savings of $1.4 million.
IN	Chronic Disease Management Program	2003	Disease management and intensive high-risk nurse management • Treatment plan developed and implemented by a case manager, working either in person or over the phone with diabetes, asthma and heart failure patients	610,000	According to the Agency for Healthcare Research & Quality: "The program showed significant reductions in three chronic disease markers in the first year: HbA1c, self-management goals and a blood pressure below 130/80;" such improvements lead to fewer complications and health problems related to these chronic conditions.
WA	Diabetes Training Collaborative, others	1999 (Pilot); Expanded in 2002 (diabetes collaborative)	Disease management • Providers trained to manage care for recipients with diabetes • Disease management for Medicaid recipients with multiple conditions	915,000	• The number of foot exams increased 21 to 50 percent; • Blood sugar levels improved 2 to 12 percent; • Blood pressure levels improved 2 to 9 percent; • Reduced cholesterol levels; • More tobacco users receiving tobacco cessation counseling; • People with chronic diseases empowered to manage their own health care; and • Improved clinical staff and patient relationships. The state projects a 12.6 percent reduction in diabetes deaths, 8.4 percent reduction in heart attacks, 7.2 percent reduction in strokes, 25.8 percent reduction in amputations and a 14.4 percent reduction in kidney failure.
VT	Chronic Care Collaborative	2003	Disease management curriculum development • Curriculum based on Institute for Healthcare's "Breakthrough Model for Change" is taught to providers and their staffs for one year • Providers report back on their success in implementing the model and the effect on outcomes for recipients with diabetes and related cardiac conditions	29 participating practices from across the state	Participating practices markedly improved diabetes-related testing. At least 90% of the nearly 2,000 patients had: • At least two tests of their blood sugar (A1c) a year; and • At least one test of their blood LDL (cholesterol) levels, and their blood pressure measured.

Figure 4.9: Medicaid Care Management Program Implementation Checklist

Medicaid Care Management Program Implementation Checklist	
Design & Implement	❒ Estimate care management costs based on prevalence, anticipated usage and intensity of program interventions ❒ Set realistic expectations for short-term cost savings, particularly if the current system leaves many unmet needs ❒ Partner with other state agencies (mental health, substance abuse, aging / long-term care, disabilities, education and public health) to avoid care management silos ❒ If partnering with an outside vendor, collaborate on a mutually agreed-upon list of short- and long-term goals in terms of costs, savings/return-on-investment, and outcomes ❒ Be flexible – care management is a process of learning and continual improvements
Identify	❒ Leverage MMIS / claims history data, predictive modeling and enrollment screening information to locate appropriate candidates in a timely manner ❒ Educate local, regional and statewide personnel to facilitate referrals ❒ Refer recipients from one care management program (nurse line, CM, UM, DsM) into other programs they need/qualify for – fostering an integrated care management program and a seamless recipient experience ❒ Clearly distinguish relationships between care management programs and other similar/applicable programs offered through other agencies (i.e. avoid "turf-wars")
Engage	❒ To achieve success, treat care management programs as any other marketable service ❒ Build awareness via posters, letters, advertisements and other promotional vehicles ❒ Ensure that all communications distributed through these programs have a single voice, are written at a low reading level, and have a warm, engaging tone ❒ Translate communications into the languages most prevalent in your state ❒ Consider focus groups and onsite workshop / planning committees to gauge the success of communications and marketing activities aimed at the Medicaid population ❒ Enlist community and faith-based organizations to promote the program
Enroll	❒ Ensure the process and requirements of enrolling in care management programs are adequate for its goals – but not overly-burdensome on the recipient ❒ Provide multiple avenues to enroll and/or participate (e.g. paper / mail, telephonic and online) ❒ Clearly state program goals and benefits upfront to the recipient
Stratify	❒ Apply appropriate clinical guidelines, protocols and other benchmarks to stratify recipients into risk pools – such as "low," "moderate" and "high" risk – that guide the individual's path within the care management program
Intervene	❒ Tier interventions according to the individual's severity and / or needs; for instance, a low-risk diabetic could benefit from printed educational materials – while a high-risk recipient with heart failure may require one-on-one nurse counseling
Monitor / Follow-Up	❒ Avoid "one-and-done" interventions – continued engagement is key to behavior change and long-term success ❒ Be responsive to changes in severity – ramping services up / down as needed ❒ Meet regularly with care management staff to discuss difficulties and develop creative approaches to solving such problems
Measure	❒ Continually measure results of all care management programs, whether administered in-house or via an outside vendor, through a risk "scorecard" or "dashboard" ❒ Publish results and successes to the public to gain public awareness and buy-in of these efforts ❒ Look beyond the numbers – sometimes real-life testimonials from recipients are more powerful than any other metric
Improve	❒ Analyze operations and results regularly to identify areas for improvement and successes that could be expanded upon or implemented in other programs

REAL WORLD APPLICATION

New Mexico's Braided Funding: Medicaid care management

New Mexico Governor Bill Richardson has pioneered a "braided funding" project, which streamlines 17 state agencies to provide more continuity in care and assistance for recipients – while reducing duplicative or unnecessary services. Under this initiative, funding streams for eligible services (e.g. food stamps, Medicaid and housing assistance) come together in a comprehensive assistance package rather than delivered through disconnected silos. By coordinating these different touch points and fostering inter-agency communication, the state – and its taxpayers – can maximize impact for its Medicaid population without wasteful spending that's prevalent in the current system.

Step 6: Leverage Meaningful Incentives.

When interviewing state Medicaid officials, we found greater variance in points of view on the use and value of financial incentives than any other topic. Some states have warmly embraced specialized plan designs that reward personal responsibility through incentive payments or a medical spending account, while others prefer to enforce a code of personal responsibility as a condition of continuing health coverage. Still, other states view financial incentives as punitive and inappropriate for any Medicaid population. As one state secretary of health and human services stated, "I would find it abhorrent that we would implement something for poor people and disabled people that we don't do for the rest of us."

In one important respect, Medicaid is like any other health insurance plan: the actions of the patient and his/her provider are the primary determinants of the cost of healthcare. Unless there is blatant fraud, neither party is ordinarily held accountable for inappropriate utilization, lack of compliance with evidence-based treatment, or waste. Consider the following statistics:

- The Centers for Disease Control and Prevention estimates that 50 percent of total health costs are directly linked to personal behavior – poor health habits such as overeating, smoking, lack of exercise, lack of sleep, substance abuse and/or not managing a chronic condition.
- Research using SHPS' claims database suggests that evidence-based standards of care are rendered by providers in no more than 52 percent of relevant treatment episodes.

Regardless of cause of poor health or quality of treatment, the state picks up the tab. Economists call this lack of accountability a "moral hazard," an issue endemic to the entire U.S. healthcare system. No health insurance program, Medicaid included, can operate efficiently without finding effective ways to drive greater accountability in patient and provider behavior. However, Medicaid programs create special challenges. While it is difficult enough to change the health habits and purchasing patterns of ordinary middle-class Americans, many Medicaid recipients face additional personal barriers that lead to poor personal health practices: poverty, lack of education, co-morbid conditions and personal circumstances. It would be disingenuous to offer incentives to such a population without the tools in place to help them overcome personal barriers. Similarly, Medicaid's low reimbursement rates and high patient volumes increase the likelihood that harried providers will not practice evidence-based medicine.

Our point of view is that financial incentives, when properly implemented as part of a comprehensive healthcare strategy, are among the most powerful tools available to change

patient and provider behaviors. They are complex to design and implement, and often attract controversy. In some form, however, incentives belong in every state's Medicaid toolkit.

Managed care and, more recently, healthcare consumerism, are two important policy trends that have arisen over the past two decades to address greater accountability. Both approaches have been used in the commercial and public sectors, and they provide a structured approach for thinking about incentive design – balancing supply and demand.

Incentives to Manage Health Risk

The traditional managed care approach employs capitation fees to limit the supply of healthcare, in effect, putting a provider or health network at financial risk for providing treatment to a covered group. Capitation is attractive to state Medicaid plans because it allows them to assign a specific covered population to a private managed care insurer for a fixed fee. Some form of managed care can be found in all but two states (Alaska and Wyoming). It has been most effective in specific environments, such as urban TANF populations, where referrals to large specialty practices are major cost risks. As with any artificial price control scheme, however, there is a structural tendency for abuse, such as improving short-term profitability by restricting access to care, rather than by achieving better health outcomes through improved prevention, quality and efficiency. Not surprisingly, patient satisfaction with managed care plans has been highly variable. In commercially-covered employee groups, traditional managed care plan designs have declined precipitously in favor of newer approaches that identify and reward provider groups with superior outcomes.

Incentives to Manage Quality

Instead of a system that places providers at financial risk, pay-for-performance (P4P) initiatives reward healthcare providers that follow accepted standards of care and offer superior levels of care. Studies have shown that such incentives improve HEDIS measures; they can also entice more providers to participate in a state's Medicaid program – increasing recipients' healthcare access. Today, only 12 percent of all P4P programs are found in Medicaid.

Incentives to Manage Health Behaviors

Consumerism attempts to manage demand for healthcare by providing financial incentives to patients to change behavior, along with health information tools to help them manage their personal health and select high quality providers. Early results within commercial group populations have been highly promising, suggesting that the right combination of financial incentives can encourage consumers to research their health conditions, comply with evidence-based treatment guidelines and explore the use of generic medications. The challenge for consumerism has been that different populations require different types of incentives. For example, a $20 co-pay may have little impact with a commercial population, but may be too aggressive in a Medicaid environment.

A person-centric approach to Medicaid gives recipients a vested interest in healthcare decisions and dollars. This does not mean that recipients must shoulder an economic burden; rather, it means that by providing convenience, incentives and access to information, recipients can become "smart healthcare shoppers."

For example, a shared savings account would allow recipients to use a debit card for eligible health-related purchases, access coverage for wellness or preventive services, reward healthy lifestyle changes with additional contributions – and even resolve access hurdles by covering non-emergency transportation to healthcare providers. Accounts can also be structured to allow for unused funds in a given year to roll over and pay for future medical insurance and health expenses, providing an incentive to seek needed care and save for a "rainy day." Medicaid recipients are interested in accepting such personal responsibility; according to a recent Gallup poll, two-thirds reported that they would

be "very likely" or "extremely likely" to switch to a Medicaid plan with a shared savings account.

At the end of the day, a state's goal should be to motivate recipients to change unwise healthcare habits or utilize the current system in a manner that creates better health outcomes. Providing tools like spending accounts, partnering with health plans that offer consumer-driven options, offering a shared service funding mechanism with properly aligned incentives and allowing easier access to care are all tactics that point toward engaging recipients in a thoughtful, proactive manner regarding their healthcare.

Effective incentives are not designed in a vacuum. Successful implementation of financial incentives involves several major program elements:

- A well-defined, measurable objective linked to the use of incentives.
- A clear definition of:
  - Eligibility requirements;
  - Types of behaviors to be rewarded;
  - Verification;
  - The size of the incentive;
  - Source of funding;
  - The timing of payment;
  - Communication of the program; and
  - Integration of the incentive with other program elements.
- A careful review of the feasibility for an individual to comply with requirements and earn an incentive.

The optimal Medicaid program will encourage recipients to make responsible lifestyle and healthcare decisions; motivate providers to participate in the Medicaid network and provide high quality care to Medicaid recipients; and leverage tools – from the public and private sector – to expand recipient access and boost performance results.

INSIGHT

Challenges faced by Medicaid recipients

Rhonda Medows
Georgia

Commissioner, Department of Community Health

Medicaid is a microcosm of our larger healthcare system. The same problems that exist in the private insurance market loom large in the public sector. Georgia has 1.7 million uninsured individuals, and access to affordable health insurance options is a challenge. We need a coordinated, objective database of current, accessible healthcare options and we need to develop new options with "menus" to offer the healthcare consumer new choices. And we need an effective monitoring mechanism to gauge its effectiveness.

Each "player" in the Medicaid system has a responsibility to help improve the program. Our state agency's responsibility lies in developing a common statewide goal that includes healthier recipients, assuring quality care, enabling access to various health coverage options, investing in current and future generations' health via a focus on prevention and educating the population. It's also our responsibility to implement objective measurement systems and quality improvement processes.

Recipients and other healthcare consumers need to bridge the lack of knowledge gap, become motivated to use available resources, ask for new resources that will help them bridge the gap more quickly and be proactive when it comes to preventive health and healthy lifestyle changes. Providers must expedite transparency in their quality and pricing structures so patients can begin the evolution to becoming healthcare "consumers."

There is a need for long-term commitments and accountability by consumers, providers, payors and the government to build and deliver a true integrated healthcare system.

REAL WORLD APPLICATION

Healthy Behaviors in Florida: Reforms to improve care

Florida has the fourth largest Medicaid population in the nation, and is the third largest in Medicaid spending. In the late 1990s, Florida was one of the first states to implement disease management programs for its Medicaid population. Since then, the state has remained on the cutting edge with its Florida Medicaid Reform program. It offers recipients greater choice and decision-making over their healthcare. To help them make the best choices, counseling is provided via call centers, mailed enrollment packages, online web sites, in-person sessions and community meetings.

One of the most interesting components of Florida's reform program is the "Enhanced Benefits Account Program" (EBAP) – where recipients earn credits in a personal healthcare spending account for activities labeled "healthy behaviors." These behaviors, which can be offered by a recipient's health plan, community center or other non-profit organizations, include keeping doctor appointments, getting preventive screenings and participating in wellness programs. The program records participation when either: 1) the health plan reports that the recipient visited the doctor or had a procedure deemed a healthy behavior; or 2) the recipient submits an Enhanced Benefits Universal Form to the health plan that documents a completed healthy behavior.

Each fiscal year, recipients can earn up to $125 worth of credits to purchase approved health-related products – including over-the-counter medicine, vitamins and dental supplies – at any Medicaid-participating pharmacy. All recipients that enroll in a Medicaid Reform Health Plan are eligible for the program, and no separate application or process is required to participate.

Linking incentives to healthy lifestyle choices has long been a best practice in effective care management programs. Perhaps most ground-breaking, unused credits can still be used to pay for healthcare supplies after a recipient leaves Medicaid. This set-up is very similar to health savings accounts (HSAs) in the commercial healthcare world.

Policy Takeaways: Incentives

- **Reward personal responsibility.** Recipient incentives, whether freestanding or linked to personal accounts, can reduce inappropriate utilization, entice healthy behaviors and boost participation in care management programs.
- **Reward provider excellence.** Pay-for-performance models can widen participating provider networks, boost compliance with evidence-based medicine, and improve healthcare access and outcomes for recipients.
- **Align, integrate and coordinate.** Linking incentives with prioritized health risks, incorporating them into plan designs and coordinating them with other programs (e.g. health record, case system) will maximize their impact and drive desired results.

Figure 4.10: Transforming Incentives

Stakeholder	Current Financial Arrangement	Incentive Strategy
Federal Government (CMS)	• Provide open-ended matching dollars to states • Bias toward rewarding Medicaid programs in close compliance with federal statute • Waiver process slows down innovation process at state level and drives fragmented programs	• Continuous monitoring of health outcomes • Provide "overrides" to states for improved health outcomes • Manage against broad principles and outcomes • Allow states flexibility to invest Medicaid dollars for other social programs that improve health outcomes • Encourage measurement and technology standards
State Medicaid Programs	• Bias toward optimization of federal match rather than best impact / value • States financially "punished" for doing the right thing	• Allow states to utilize unspent money on alternate social investments • Build federal match around results
Providers	• Rewards volume of procedures, acute care and institutional care • Limited accountability for health outcomes • Limited incentive for thriving practices to accept Medicaid reimbursement • Bias toward abuse of medical coding	• Reward doctors with timely, competitive reimbursement for: - Providing a medical home - Integrating services with care management - Long-term health outcomes - Adopting shared medical case management technology
Third Party Health Plans / Support Vendors	• Classic managed care programs reward gatekeeping and cost controls, rather than lower cost through better health	• Percent of fees at risk to achieve independently verified outcome measures - Biometrics - Health outcomes - Satisfaction
Medicaid Recipients	• Financially biased toward overuse of ER, acute and institutional care • Limited support for social programs to mitigate health risk	• Health opportunity account • Modest incentive payments • Allowance to retain partially subsidized coverage as income increases • Allow alternative funding to support health coverage for the uninsured • Provide financial alternative to institutional care for elderly and disabled

REAL WORLD APPLICATION

South Carolina Medicaid Choice: A study in consumer-driven Medicaid

South Carolina is proposing a Medicaid coverage plan that integrates spending accounts (personal health accounts – PHA), personal health incentives and options for consumer choice. The intent is to create an environment in which providers and insurers are free from bureaucratic requirements and compete for the consumer's dollar. As indicated in the plan outline below, three general categories of care are addressed: acute or general medical care, community care for the disabled and elderly and institutional long-term care.

Acute medical coverage

- The plan offers a traditional fee-for-service plan to recipients that will cover major medical items and physician visits only. Non-life threatening services require co-pays. Drugs for life-threatening conditions are covered, as are immunizations and other "medically necessary" items.
- A PHA will accompany the plan to pay for co-pays in the fee-for-service plan and purchase other types of coverage (e.g. eye care, prescription drugs, dental). It is accessed through a debit card with medical and insurance payment coding.
- Alternatively, the actuarial value of the fee-for-service plan plus the PHA may be used to purchase private sector networks and/or managed care plans marketed through an insurance and provider exchange (IPE) operated by the state.
- Unused PHA funds will roll over for recipients renewed by the state. Recipients leaving Medicaid may roll over a portion of the PHA into a private-sector health savings account (HSA).

Community care plan for disabled and frail elderly

- All recipients receive a PHA related to the severity of their disability/condition. Severity is determined by caseworker ratings. The PHA amount is a percentage of what the state currently spends on this type of disability.
- Recipients may use the PHA for the following:
  - To purchase needed healthcare services and supplies. Medical services, such as home healthcare, may be purchased from providers bidding at the IPE.
  - To hire relatives to perform services in addition to private providers, however, family members must register with the IPE to receive payment.
- Unused PHA funds may be rolled over annually, if eligibility continues. If recipient leaves Medicaid with unused funds, those funds may be rolled into a private-sector HSA.

Institutional long-term care

- The state will determine the eligible number of nursing home beds covered by Medicaid, then solicit bids at the IPE. Medicaid will continue to accept beds, beginning with the lowest bid and moving to higher bid amounts until the eligible number of beds is reached. All cost-based reimbursement will be eliminated.
- Beds are allocated to accepted bidders as vacancies occur to avoid disrupting patients. Beds are to be bid three years at a time; annual reimbursements are adjusted based on a quality index.

Source: "Reforming Medicaid in Texas." Texas Public Policy Foundation.

Robert M. Kerr, Director, South Carolina Department of Health and Human Services, summed up South Carolina's approach: "I think the role of the Medicaid agency is to lay the foundation for the program to succeed, create a competitive environment based on quality of care and price and become the glue, the coordinating entity for individuals and the system, and to do it in a fashion that the market can take hold and advance it."

INSIGHT

Change in the current Medicaid system

There are many facets about Medicaid one could change, but I would start by subsidizing, on a graduated scale, entry into the larger healthcare system for Medicaid recipients. I would create products that would allow recipients to be absorbed into the mainstream. Medicaid has been a claims processor for a very long time. We didn't worry about cost savings. The claims came in, we paid them. The biggest worry was how fast the claim could be paid. In reality, we should have been utilizing the existing marketplace by subsidizing entry into the market, thereby preparing Medicaid recipients for what they are going to find in the commercial market.

I think we've lost sight of the difference between insurance and healthcare. Insurance is a matter of mitigating risk. I purchase insurance because I am afraid I may not be able to afford a possible, or probable, event. We've turned healthcare into a prepaid plan where we anticipate covering everything. It used to be rare to see maternity coverage in policies. You knew it was an event that was going to happen; therefore, it wasn't insurable except in certain circumstances. Now, most group insurance plans provide maternity coverage. Through convenient payroll deductions to purchase generous benefit plans, we have nearly reached the point where we have separated the individual from the cost of care. I think we've got to move to a product that an individual would purchase to cover catastrophic care and the routine needs are handled outside of insurance-based products. The Medicaid population is a group of individuals that cannot afford access to care like many others, so you have to provide a little more coverage. However, I think the goal for Medicaid should be to provide access to mainstream products, as opposed to creating a separate avenue or line of care.

Medicaid seems to be expanding, not minimizing its impact. For example, we used to worry about "crowd-out" in the early 90s. Anytime Medicaid programs were expanded, the insurance industry worried about Medicaid taking over their premium based clients. Now we don't hear a lot about that because it is not unusual for an employee to drop group benefits if they can obtain Medicaid. That is the reverse of where we need to be heading. Proof of that is South Carolina's Medicaid program covers 60 percent of all births in our state, and that is way too high. We need to find a method by which we can keep pregnant women in mainstream-type coverage for healthcare and not reliant on Medicaid.

Robert M. Kerr
South Carolina

Director, South Carolina Department of Health and Human Services

"I think we've got to move to a product that an individual would purchase to cover catastrophic care and the routine needs are handled outside of insurance-based products."

Step 7: Institute Flexible and Accountable Regulation.

Transformation requires new approaches to long-standing problems. As fiscal pressures grow on states, the federal government has offered greater flexibility in administrating Medicaid programs – such as the recent DRA. Our experience and research points to three regulatory steps that could correct the misalignment between spending, measurement and delivery commonly found in Medicaid.

Array the flow of savings and investments to achieve wide-scale social benefits. As discussed in Chapter 2, Medicaid's funding set-up serves the perverse purpose of rewarding increased spending, creating a strong barrier to structural reform. Instead, states should be rewarded for efficient Medicaid programs, allowing greater discretion in investing resulting savings into other social programs and budgetary needs. Education and job training – as well as public health programs outside of Medicaid – offer long-term benefits to a wider swath of a state's population. Such investments are also proactive ways to reduce the need for social safety nets in the future.

To be sure, this goal appears to be a no-brainer that's easier said than done. But in reality, little has been said or done about the flow of savings and investment related to Medicaid due to the fear of losing federal dollars. Greater research is needed in this area; and lawmakers, administrators and public health officials – at the federal and state level – should contribute to the debate on this topic.

Hold programs accountable to their results. To truly gauge the success or failure of Medicaid services, oversight should be redesigned around measurable outcomes. While these metrics will vary due to unique program designs and goals, four common measurements include total population health, recipient access to care, satisfaction levels (for recipients and participating providers) and case audits. States with greater discretion in pooling funds from related social services can improve these program results by creating a single, efficient delivery model.

Improve service delivery and performance via CMS waivers, pilot programs and public-private partnerships. Many of the real-world applications showcased in this book resulted from pilot programs or waivers granted by CMS and take advantage of partnerships between the public and private sectors. States can also improve access to care to those with multiple chronic illnesses or catastrophic conditions through high-risk pools and special-needs plans. These programs provide specialized care for populations with very frequent, intense or unique healthcare requirements, such as people with HIV/AIDS.

In the end, innovative experimentation is the only way to uncover best practices and increase the momentum of change within the Medicaid system as a whole.

Policy Takeaways: Regulation

- **Reward savings not spending.** Wisely investing savings into other key social programs offers wider, longer-term benefits than the unsustainable trickle-down economics of Medicaid spending-saving-expansion.
- **Redesign oversight methods.** Holding programs accountable to measurable outcomes validates what's working – and identifies areas that need improvement.
- **Intertwine delivery protocols.** Innovative approaches and partnerships can bridge gaps between program goals and actual results.

INSIGHT

Creating Medicaid reform

If we're discussing true Medicaid reform, ask yourself; "If I could design a Medicaid program from scratch, what would it look like?" We've always tried to solve the Medicaid problem within the Medicaid silo, because, under the circumstances, that's the best we could do. The reality is, if you want to deal with Medicaid, you have to deal with the uninsured.

Medicaid recipients roll in and out of eligibility. Recipients are Medicaid HMO members one month and the following month rotate out of Medicaid eligibility and return to having no coverage. Consequently, they don't have a medical home. We provide a medical home in the system I operate. We have 14 community clinics, whether you're in Medicaid or uninsured, we provide services. We don't get paid if they're uninsured, but we address the issue of creating access and create points of entry for both Medicaid and the uninsured populations. Unfortunately, most communities don't have this in place.

If we were to use the Massachusetts model, for example, as a model for a federal plan, we start with the premise that everybody will have insurance. If you're between 75 percent and 300 percent of the federal poverty level, you receive a tiered subsidy for health insurance. Below that, or if you're uninsured, unemployed or disabled, you qualify for Medicaid. In this model, you move numerous people out of Medicaid and into private insurance.

The fundamental concept behind insurance is to create large pools of risk and spread the risk. In Florida, there are 1.6 million children in the Medicaid and SCHIP program. Most of those children are healthy. What we've done with the Medicaid and State Children's Health Insurance Program (SCHIP) programs is take the healthiest populations and carve them out of the insurance market risk pools, thus creating a healthy risk pool in Medicaid and SCHIP. We're left with the 35-and-older population in the private insurance market where the risk pools are spiraling out of control. We should be asking: "How do we change this model so we leverage all the money we're spending in Medicaid and SCHIP and strengthen the private insurance marketplace?"

If I could create true reform, I wouldn't carve out Medicaid. I would advocate a system that creates a broader or national risk pool and uses private insurance where the provision of coverage allows the consumer choice and provides some flexibility in benefit design – a system that creates larger risk pools that allows you to place Medicaid eligible SCHIP kids and young adults into these insurance pools and empower them to buy coverage through the private marketplace as opposed to a true government-funded program. It might cost the federal and state government more to strengthen the private insurance marketplace, but consider the benefit of stabilized insurance premiums for employers.

Alan Levine
Florida

Former Secretary,
Agency for Health Care
Administration

"I would advocate a system that creates a broader or national risk pool and uses private insurance where the provision of coverage allows the consumer choice and provides some flexibility in benefit design."

Medicaid Transformation Matrix

Core Principles → / Action Steps ↓	Align structure and Incentives	Promote social advancement	Manage health and financial risks	Provide integrated delivery
Identify, Quantify & Prioritize Risk	• Identify overall program goals and critical metrics • Quantify the cost impact of achieving target goals.	• Correlate health scores with social health measures: - Quality of life - Independence - Employability - Educational performance (children)	• Develop risk scorecard • Adopt total population approach • Develop quantitative risk score linked to healthcare spending: - Individual - Aggregate • Take a health snapshot of entire population and sub-segments	• Update metrics continuously based on claims, pharmacy and biometric data • Use health risk score to prioritize strategies • Link interventions and changes to total aggregate health
Align Plan & Program Design with Strategy	• Leverage incentives to modify and reduce unhealthy behaviors • Create provider pay-for-performance incentives	• Identify social issues that create barriers to care and self-management of health: - Lack of information - Transportation access - No care coordination - Co-morbid mental health	• Link risk drivers to overall cost: - Compliance - Quality of care - Utilization - Access to care	• Use risk drivers to target greatest healthcare barriers for a specific group or individual
Design a Person-Centric Delivery Model	• Consider risk sharing with providers • Consider consumer-based incentives • Identify high performance specialty networks to manage chronic diseases	• Incorporate empowerment into plan design • Encourage recipients to graduate from the Medicaid program	• Identify population segments with similar risk profiles • Design benefit plans and programs based on unique needs of population sub-segments	• Identify core services of greatest assistance to each population sub-segment • Develop overarching delivery model
Implement Advanced Technology	• Create platform to manage incentives and complex rule sets • Coordinate incentives with health record and case system on one integrated technology platform	• Identify allied social programs that can be coordinated and co-delivered via a single technology platform • Develop contact/relationship management capabilities to facilitate social/health cases	• Establish protocols for electronic personal health record • Create health analytics and 360 degree view to manage recipients • Ensure seamless exchange of data between sub-systems	• Implement personal health records • Institute federal standards for health records and health data exchange • Leverage 360 degree view of recipient across all services and providers
Coordinate Care	• Create small, yet meaningful, incentives for participation in health programs • Fund discretionary health debit cards for ancillary services • Use discretionary funds to assist individuals with care	• Ensure multiple, diverse touch points: - Field offices - Enrollment • Create multilingual and culturally-specific programs • Link care coordination with social programs to create personal relevance • Provide training and education to support back to work initiatives	• Develop an integrated plan that prioritizes interventions by risk • Provide care coordination across the continuum: - Well - At Risk - Chronic - Catastrophic • Quantify impact of individual interventions	• Adopt person-centric case approach, promoting coordination of state clinicians, providers, pharmacy and social services
Leverage Meaningful Incentives	• Reward providers for health outcomes, not procedural volume • Provide discretionary health accounts to recipients • Reward recipients for prevention and compliance • Conduct field trials of controlled health accounts	• Alleviate recipient fears that seeking higher-wage work removes health coverage by: - Determining eligibility through a continuous formula - Offering partial eligibility based on income (not "all or nothing")	• Align financial incentives with prioritized health risks, behaviors driving risk: - Preventive care - Provider performance	• Integrate incentives into plan design
Institute Flexible & Accountable Regulation	• Reward states for saving money, not spending it	• Invest savings from efficient Medicaid programs into other key social programs	• Redesign oversight around measurable outcomes, not program designs: - Total population health - Access to care - Recipient and provider satisfaction - Case audits	• Provide states greater discretion in pooling money from related social programs into a single delivery model • Establish precise protocols for privacy and access to personal health records.

In Summary

Many of the steps outlined in this chapter require effective collaboration, coordination, oversight and communication between two or more stakeholders. Due to the complex interplay between these various entities, Medicaid transformation requires action from multiple levels to succeed – particularly *federal* and *state governments.*

Transformation at the Federal Level

Federal regulation, chiefly through legislation and CMS, can hinder or help Medicaid transformation. The Deficit Reduction Act (DRA) of 2005 illustrates how federal actions can have sweeping consequences for states. Its regulatory and legislative changes are expected to save the federal government $28.3 billion in projected Medicaid costs through 2015, but may impact the state's share of the cost. Its changes impact nearly every facet of Medicaid – from eligibility, benefits and cost-sharing to provider payments and program integrity. However, the final impact largely depends on what actions states and CMS take in the coming months and years, according to the Kaiser Commission on Medicaid and the Uninsured.

Whether CMS issues guidance on provisions in the DRA and if so, how it does so – through formal regulations or through less formal means such as letters to state Medicaid directors – have important implications for transparency in Medicaid policymaking. The level of transparency and opportunity for public input in the policy-making process can be critical in understanding changes that could have implications for low-income beneficiaries served by the program. The timing and form of future guidance on DRA-related provisions could have implications for public understanding of Medicaid changes, for the way states administer their programs and for the ways in which beneficiaries use the Medicaid program.

In our discussions with state health secretaries, the DRA received mixed reactions. While some state health secretaries believe it gave them greater latitude for decision making, others (Republican and Democrat alike) pointed out that CMS was often inconsistent in fast-tracking the approval of new ideas, and tended to "wax and wane" in their oversight role. Regardless, everyone agrees that the DRA creates both added fiscal pressure and opportunities for innovation.

We anticipate further discussion and clarification of the DRA, and do not discount the possibility of new legislation. We applaud and welcome vigorous debate, and urge legislators to test their ideas against our four fundamental principles for Medicaid transformation.

Transformation at the State Level

While change and clarification are needed at the federal level, there is near-universal agreement that states must act now rather than wait for further federal action. Our research suggests that innovation is thriving at the state level. Despite numerous challenges, many states have successfully launched new programs, tools and policies to take control of rising costs, create a more efficient Medicaid program and improve the health status of their Medicaid populations.

However, true transformation does not come from piecemeal improvement. An effective Medicaid program should feature:

- An intelligent and person-centric model of coverage and service, with appropriate preventive and care management services;
- The prudent use of advanced technology, including electronic personal health records and case management tools;
- Effective partnerships with the provider community;
- Promotion of social advancement, personal independence and continuity of coverage for those seeking to better their condition; and
- The ability to continuously monitor and measure the impact of interventions, identify key health risk drivers and make continuous program improvements.

The states making the greatest progress in Medicaid reform have articulated a clear vision of their future, and developed long-term strategies to achieve these goals. While individual state programs are uniquely designed to meet their needs, the policies and processes for transforming Medicaid will likely be quite similar. Our research, and SHPS' experience with the government and private-sector companies, corroborates this observation. A key lesson from the private sector is that states need agreed-upon goals, a comprehensive strategy, a sensible timeline that may stretch over several years and the perseverance to succeed.

One key implication of an integrated approach is the need to transform procurement to support Medicaid and related public health programs. For example, there needs to be tight linkages and process flows between health metrics, care coordination and recipient case management. In the past, state procurement of services has reflected the underlying infrastructure – fragmented, narrowly defined programs that may not work well together. In an integrated "system" program and vendor integration are critical. Vendors need to be held accountable for strategic outcomes, not tactical activities. States need to carefully rethink how they design and position RFPs to potential vendors, and the criteria they use for assessment.

Aligned structures and incentives, social empowerment, validated health and financial metrics, integrated delivery systems – transforming Medicaid may seem an overwhelming mission. And it is true that these ideals will not be achieved overnight. Yet as with any innovation, success depends on focus, patience and practice.

Final Thoughts:
Transforming Medicaid

Medicaid has heroically served America's citizens most in need for more than four decades. We have reached a point where transformation is required – a fundamental shift in program design at every level.

Final Thoughts: Transforming Medicaid

In writing this book, we have consciously chosen the path that would best help state and federal policymakers develop a strategy for transforming Medicaid. As a result, we avoided proposing specific legislative or regulatory steps. There are already a range of specific proposals for reform. We believe that individual states and their Medicaid-eligible populations will continue to have unique requirements that cannot be precisely anticipated by federal (or even state) legislation. Beyond state innovation, a federal commission has recently issued a report on Medicaid reform with specific policy. Our goal was not to develop competing proposals or repeat what has already been articulated by others.

Rather, we have established a framework of goals and principles that permits state and federal policymakers to develop and evaluate alternate proposals as they arise. Broadly speaking, Medicaid reform should follow four foundational principles:

- Align structure and incentives;
- Promote social advancement;
- Manage health and financial risks; and
- Provide integrated delivery.

These principles are politically neutral and invite consensus. While they are simple, their implications to Medicaid and broader social policy are enormous. Sustainable Medicaid transformation will not occur without a comprehensive solution to address our rapidly aging population's need for long-term care. We cannot hope to manage the health risk of our elderly, foster their independence, create a person-centric system or align the financial incentives of the provider community in a dual-eligible system supported by two government programs with separate funding mechanisms.

We need to be solving tough policy questions to address the primary causes of demand for long-term care in future years – issues such as poor self-management of chronic disease, inadequate healthcare prior to age sixty-five, inadequate housing and a lack of flexible home care alternatives. Today, most Medicaid programs can neither measure nor fully mitigate these risks.

Similarly, we cannot foster social empowerment for the working poor by over-stimulating acute and institutional healthcare at the expense of preventive health, education, housing and access to primary care. It suggests that states need to consider social policy more holistically, and individuals need to have greater control over how money is spent on their behalf. Conversely, some Medicaid populations – for example, those who rely on prescription medication to manage mental illness – remain underemployed for fear of losing coverage. To foster social advancement, eligibility for Medicaid benefits should not rely on a binary needs test. Rather, there should be opportunities for partial coverage, with individuals picking up a greater or lesser portion of coverage expense based upon need.

Managing Medicaid's health and financial risks means coming to grips with the problem of the nation's uninsured. Many of these individuals will become tomorrow's Medicaid and Medicare recipients. It is irrational and costly to deny basic health coverage and preventive care to uninsured adults, yet generously pay for the severe medical complications that arise from poorly-managed chronic conditions – either in the emergency room or once eligible for Medicare. As an adjunct to Medicaid, SHPS and CHT recommend that states provide low-cost consumer health plans for the uninsured, with tiered contributions based on income and health risk scores. Arguably, the mandate to offer coverage to the uninsured should be supported by federal matching funds, but administered by individual states based on the unique needs of their population. These services can be rendered through commercially available health plans in a state risk pool, or through expanded eligibility in an existing state program. Regardless, states must have the tools to track the aggregate health of their entire population, not just current Medicaid recipients, and the ability to mitigate the health risks of their population through intelligent policy.

Within state Medicaid administrations, person-centric delivery requires a fundamental rethinking of how we deliver Medicaid and how we coordinate healthcare with other social services. In essence, everything changes: all recipient interactions and touch points, coordination of care and services, management of the flow of money through recipients, record keeping, and measurement of results. A person-centric workflow requires a fundamental rethinking of technology, procurement and organizational structure.

Aligning structure and incentives means identifying the outcomes we want, and creating program guidelines and financing formulas that will support those outcomes. The current flow of money within Medicaid rewards and reinforces sub-optimal public health policy, while distorting healthcare delivery by emphasizing acute and institutional care rather than personal health and well-being.

In short, we believe that our strategic framework and principles serve as a guideline for broad social reform. Its sequential outline offers insight into the iterative process of continually refining and evolving our strategy, and developing increasingly effective mechanisms for delivery.

At the beginning of our book, we noted that the Medicaid crisis is ultimately a crisis of value – high expenditure for poor results. This is not a reflection on those who have served long and tirelessly to administer and improve these programs. Medicaid has heroically served America's citizens most in need for more than four decades. We have reached a point where transformation is required – a fundamental shift in program design at every level. Let us move forward courageously, and always with the endpoint in mind – better health for all Americans.

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