MEDICAID: NEW VISION, REAL CHANGE

Medicaid is critically important to more than 50 million Americans with limited income and no other source of health coverage. The current program is enormously complex, vitally needed, and excruciatingly expensive. Its performance is unsatisfactory to beneficiaries and its financing is unsustainable for taxpayers — leading to ever-increasing expenditures to provide shrinking benefits for fewer people.

The system is fundamentally flawed. Past changes have proven to be little more than band-aids on faulty foundation. Proposed solutions only tinker around the edges, attempting to tackle one or another aspect of the underlying problem. We cannot get better results by doing what we have always done.

We must embrace a new vision — guided by simple but ambitious goals and unfettered by past practices. We must create a new system built on a foundation that fosters continuous improvement in care and outcomes for patients. We can and should strive for a high-performance Medicaid program. High performance focuses on patients and demands innovation from providers. High performance Medicaid produces better value for patients and taxpayers.

Successful reform is not a static commodity, but a change in the dynamics of the system to stimulate a relentless effort toward improvements in quality and cost-effectiveness of healthcare. Our reform proposals should not be bound by the features and methods of today's Medicaid; we must extend our reach to express a new way of delivering health care—what would Medicaid look like if we were creating it for the first time today?

ESTABLISH A BOLD VISION

In our vision, the future Medicaid program is patient-centered, prevention focused, outcome-oriented, market-based and fiscally responsible.

Patient-centered. Donald Berwick, professor in the Department of Health Policy and Management at Harvard School of Public Health, proposes a simple formula for patient-centered care, "Nothing about me without me." When adopted as a key feature of Medicaid transformation, this principle is even bolder. Too many people assume Medicaid participants are not up to the challenge of making decisions about their own care. They may be poor, but they are not ignorant of their own health. They have the most complete knowledge of their conditions, needs, and abilities. They are the best ones to be in charge of their own health care. Their empowerment makes a difference—not just in what services they receive, but in the impact of those services on their health.

Patients and providers must be partners in the pursuit of better health outcomes. This partnership should be a fundamental design principle for the transformation of Medicaid. One of the important ingredients to enable this partnership is universal adoption of electronic medical records that function in an interoperable network environment. Creating this electronic information infrastructure will facilitate care coordination, but also enable patients to stay more involved and better informed about their care.

Medicaid should use its buying power to change the usual procedures of health care organizations and professionals. The movement to patient-centered care will advance significantly when payers experience positive benefits of customized information and communication strategies. Patient education should forge effective partnerships between providers and patients. Medicaid can transform health care by creating a market environment in which consumers direct resources to those providers who are responsive to their needs and capable of delivering quality services.

Prevention-focused. Good health care begins before the onset of disease or the occurrence of injury. Despite the extensive literature on the value of prevention for reducing the incidence of disease and mitigating the impacts of health problems, our investment in these areas is miniscule —less than two percent of health spending. This proportion contrasts starkly with the estimates that as much as 90 percent health spending is devoted to diseases and complications that might be prevented or lessened by lifestyle choices.

Several changes are necessary to establish a clear focus on prevention. Consumers must be educated and motivated to take personal responsibility for improving their own health. Additionally, we must facilitate payment for primary, secondary and tertiary prevention services. Delivery of these services should be integrated into health service delivery so that health promotion and disease prevention as well as disease management are incorporated into the routine of clinical care for acute problems.

We can motivate patients to improve their own health with information and incentives. Information and education are the standard methods for helping people make healthy choices, but efforts to inform and educate participants will significantly improve when achieving healthy outcomes becomes the basis for evaluating performance and earning greater market share. Incentives for consumers are another important key to effective prevention and health promotion. Medicaid participants will respond positively to credits or other types of rewards for healthy behavior. These earned credits should be applicable to a variety of health-related products and services.

Outcome-oriented. Our pursuit of quality care must extend beyond the short term or immediate results of specific procedures. We need to set our sights on achieving better health for Medicaid participants. Measurement of outcomes requires a broad view of the patients' conditions as well as a long view of those conditions over time. Transparency of outcomes not only allows consumers to select the best performing providers, it also spurs providers to improve processes and methods to achieve better results. We must move beyond the initial efforts to publish quality indicators for specific procedures. While useful, these fragments of information are, in and of themselves, insufficient. Transformation toward an outcome oriented Medicaid program requires the development of new measures—standards that will tell a more complete story of the results of clinical care.

Market-based. Competitive markets are the most efficient means of achieving optimal allocation of resources. The failure of competition in the health care field is evident by the rising costs and the persistent quality problems. This evidence does not mean competition cannot work in health care, only that it is not working now because we compete in the wrong way over the wrong things. As noted in Michael Porter and Elizabeth Olmsted Teisberg 's latest work, *Redefining Health Care*, competition in health

care "has gravitated to a zero-sum competition in which the gains of one system participant come at the expense of others. Participants compete to shift costs to one another, accumulate bargaining power, and limit services. This kind of competition does not create value for patients, but erodes quality, fosters inefficiency, creates excess capacity, and drives up administrative costs…."

True health care reform requires a transformation of the nature of competition. Medicaid reform should install value-based competition by building the infrastructure for meaningful measurement of results of care and services, integrating service providers, and helping consumers use the buying power of Medicaid to purchase and reward good results.

Fiscally responsible. We should strive to stabilize costs and get better value for what we spend. State and federal spending for the Medicaid program exceeds $228 billion. This amount is daunting, but the persistently upward trend threatens states' financial status and makes a noticeable dent in the federal budget. The factors affecting growth in health spending are complex, but they do not have to be inexorable. We must achieve a position of intentional budgeting for health care in which we stake out our level of investment and we restructure our expenditures to ensure our purchase of health services delivers optimal value for patients.

DEFINE CLEAR GOALS AND IDENTIFY CRITICAL COMPONENTS

Several central goals provide the foundation for the new Medicaid: empowerment for consumers, promotion of prevention, integration and coordination of services, flexibility for providers and Medicaid participants, and value-driven spending for beneficiaries and taxpayers. Methods for achieving these goals may vary, but certain components are essential. The effort to achieve these ideals should be apparent throughout the Medicaid program.

Participants and their families are empowered with meaningful choices of quality health services.

- Flexible benefits: Different consumers need different types of services. Loosening the reins on benefit design will provide the environment needed for innovation and diversification. Niche providers who specialize in particular populations or conditions will have the opportunity to test new and better ways to meet consumers' needs.
- Choice counseling and other support for consumers: Consumers should make these choices, but they need support and information to assess the various alternatives. Choice counseling must include ready access to information as well as varying levels of support to respond to individual consumer needs.
- Measurement of results for specific conditions: Enabling consumers to make quality choices depends on our ability to measure and compare results. Our initial moves toward measuring quality have been baby steps that focus on the components of quality—process and procedures. We need to measure outcomes for conditions and let people know in understandable terms where to get the best care for these health problems.

- Multiple sources of quality care: In health care, it is common to find virtual monopolies, such as geographic areas or programs with only one source of care. Medicaid must cultivate the development of participating managed care entities and provider groups to foster competition, which yields better results.
- Understandable information on comparative performance: The next generation of performance measurement must be created from the point of view of the consumer — not the researcher or the provider. Consumers are likely to assess performance from the lens of the conditions they experience rather than the procedures that are conducted.
- Competitive market based on value: Consumers need to be able to "vote with their feet" and choose providers or plans based on their experiences and needs as well as providers' track record for quality outcomes.
- Opt-out: A commitment to consumer choice requires an option for participants to take their Medicaid premiums out of a government-sanctioned system and into the private market.

Healthy practices by participants are encouraged and rewarded.

- Payment for preventive services: Funding for prevention must be an integral part of Medicaid financing—not an add-on or an afterthought. Resources from Medicaid premiums must be directed toward prevention. When providers are evaluated based on outcomes for specific conditions, the value of primary, secondary and tertiary prevention services will become obvious. In this way, prevention will become a central part of health care delivery.
- Health literacy: Understanding health risks and health consequences is a first step to accepting personal responsibility for one's health. Providing information is a way of providing health care. Not only should we offer information but we need to assist consumers in developing the skills for independently accessing and using this information to improve their own health.
- Ability to earn credits or additional benefits: Immediate and tangible rewards, such as increased benefits or credits that can be used to purchase other services, should be use to motivate and reward consumers who take responsibility for improving their health or managing their chronic disease.

Providers succeed by promoting health, identifying disease at an early stage, and managing chronic illness or disability appropriately.

- Financial incentives, e.g. risk-adjusted premiums: Achieving better results depends on rewarding providers for early identification and effective management of disease. One way to accomplish this objective is to pay providers more for sicker individuals. We already spend more for sicker people but we do so ineffectively through more intensive acute care or through a patchwork of supplemental programs and services. Consolidating these resources and allocating them based on medical needs will promote more effective and efficient health care – for the individual patient and the system as a whole.
- Integrate home and community based services: Developing an integrated system of care will encourage utilization of a wide range of home and community based services. Many programs offer these services, but they are hampered by

fragmented service delivery and lack of coordination. Integration begins by financing these services through a medically-appropriate premium that must be used in the most cost-effective way to achieve optimal results.

- Measurement of outcomes for specific conditions: We need to evaluate the effectiveness of care for a complete cycle - from initial onset through rehabilitation. This approach to measurement encourages health promotion and disease management because providers' performance is judged based on the effectiveness of their efforts to promote health, reduce risks and minimize the impact of chronic illness.

Health services are coordinated and delivered through integrated provider networks.

- Premium-based financing: After more than 40 years of relentless increases in health care spending, Medicaid requires a new financial paradigm. The challenge is to put the purchase of health care on a sound economic foundation—not to reduce our investment in services, but to secure better results and more rational and organized care systems. We should pay for health services through monthly premiums that are set at rates that are actuarially sound and appropriate to meet the medical needs of Medicaid participants
- Integrated provider service networks: Medicaid today is complicated and fragmented. Participants often struggle to find participating providers. Often, they must restart their search for sources of care each time a new condition or injury occurs. They deserve better. Using integrated service networks—both HMOs and other coordinated care networks—we should offer clearly recognizable access points for all type of needed service.
- Managed care: Managed care is not limited to Health Maintenance Organizations, but includes any organized system of care with active coordination services. All forms of managed care—HMOs and others—are welcome in the new Medicaid. The key to their success will be their ability to manage in ways that produce better value for consumers.
- Electronic health records: Integration and coordination of care depends on readily available and transferable information. In this area, the role of government is critical because the fundamental infrastructure and the standards for interoperability depend on government action.

Integrated long-term care services for seniors and persons with disabilities in order to provide a seamless continuum of medical care and other needed support services.

- Coordinated care networks: Vulnerable populations especially deserve and need coordinated care to ensure access to the right services at the right time in the right setting.
- Integration of home and community based services: Much of the services needed by seniors and persons with disabilities are home care or other community based supports. Seniors and other persons with disabilities should not have to hunt for these services. Integration requires the development of coordinated networks and resource agencies that can serve as one-stop entry points for all types of care.

- Consumer-directed care: When participants control and direct the resources provided for them, they will be able to better meet their own unique needs. We can trust consumers to make these decisions, but we must also provide them the information and support they need to evaluate their choices.

Innovation and flexibility in benefit design and service delivery that produce better outcomes are encouraged and rewarded.

- Flexible benefits: Medicaid participants are a diverse group who should be able to secure the benefits most suited to their needs. While some core services should be available to all, Medicaid programs should offer a cafeteria of other benefits. In a more flexible environment, we can expect the emergence of new benefits.
- New forms of service delivery: Today, health care is dominated by the face-to-face encounter between a clinician and a patient. In the future, health care providers should develop new forms of caring for patients. These innovations should take advantage of communication technology and utilize the resources of a broad range of health professionals.

Medicaid spending buys value—outcomes per cost—for consumers.

- Value-based competition: Medicaid's primary objective should be to increase value for patients. Value is both quality outcomes and cost-effectiveness. In this environment, providers win by delivering superior care efficiently. Participants will also win when Medicaid stimulates better quality and more efficient use of resources.
- Assessing value: Buying value requires knowing it when you see it. Up until now, evaluation of Medicaid programs and services has been sporadic and piecemeal. We should re-direct our attention to the establishment of a cohesive and universal framework for evaluating performance. Value is defined as the quality of outcomes per dollar of spending. To assess value, we must create new measurement systems for evaluating results over a full cycle of care as well as tracking and measuring expenditures over time.
- Transparency: Valid, reliable and comprehensive data is essential to the creation of value measurements and the establishment of a value-based competitive system. We need to move beyond the disaggregated bits of information that cloud understanding into a health information system that contributes to understanding and quality improvement.

Medicaid spending is sustainable for taxpayers.

- Premium-based funding: Sustainability depends upon taking control of how much money is spent rather than signing a blank check. In a premium-based system, government provides a specific amount of money for each enrollee. Expenditures grow when the enrollment increases and spending may grow due to other economic factors. However, the rate of growth for Medicaid, like other government-funded services, should be a deliberate choice rather than a surprise. Defining the amount of premium to be spent will provide a necessary ingredient for the fiscal discipline essential to achieving better value for participants.
- Premium components: Consumers may benefit from greater flexibility if we separate the available financial support into those portions necessary for insuring against catastrophic care and the funding that may be necessary for routine and

ongoing medical needs. A significant share of the demand for medical care does not fit into an insurance financing model; in other words, the need for the service is not unpredictable or catastrophic. We should have the ability to separate the funding for true insurance coverage from the funding needed for pre-paid health services that we know will be utilized at some basic level.

FOSTER A PROCESS OF TRANSFORMATION

The path of welfare reform should be the model for changing Medicaid. After establishing clear goals and strategies for reform, we should enable states to become laboratories of change. The Deficit Reduction Act was an important step in the right direction but Medicaid programs are still burdened with stifling federal regulations and cumbersome bureaucratic processes. We need to break these barriers and trust state governments to pursue reform in a responsible manner that serves the best interests of their residents.

Health care is enormously complex and must respond to a variety of human conditions as well as differences in the scope and distribution of resources for service delivery. While we can establish a sound foundation for change by articulating basic principles, it is unreasonable to specify in stilting detail the manner, form or exact timing of change. We should give states wide latitude in determining the mode and method of transforming Medicaid. The federal responsibility to Medicaid participants does not require micromanagement. Clear goals and objectives along with public oversight of performance are more effective techniques for producing better results.

NEVER GIVE UP

The transformation we are seeking is not a static result, but a dynamic change process that continuously adapts and reinvents itself to improve care and achieve better results as well as greater cost effectiveness. We should begin immediately, but we cannot expect to finish anytime soon. The dysfunctions we face are too numerous and the transformation we desire is too sweeping for quick results. We must remain steady and steadfast while we pursue these goals—standing by our original principles and adjusting the details when we see opportunities to do better. With this commitment, we can deliver better value to Medicaid participants.

SEVEN PROPOSALS CONSISTENT WITH A NEW VISION FOR REAL CHANGE

CATEGORY	TITLE/ THEME	PAGE IN FULL CATALOG	SUBMITTED BY	SUMMARY	CROSS-REFERENCE TO "MEDICAID: NEW VISION, REAL CHANGE"
Health IT	Innovation Adoption	19	Melanie Bella	Federal government to work in partnership with states and private sector to create the adoption of health information technology in Medicaid – such as decision support tools, quality measuring tools, electronic medical records, personal medical records, and health information networks - by providing enhanced administrative match and upfront investment in technology to states.	Page 1: Patient-centered system Page 2: Prevention-focused system Page 2: Outcome-oriented system Pages 2-3: Market-based system Page 3: Fiscally responsible system Page 3: Choice counseling Page 4: Health literacy Page 5: Electronic health records Page 5: Consumer-directed care Page 6: Assessing value Page 6: Transparency of quality
Long Term Care	Improving Care for Dual Eligibles	17	Melanie Bella	Integrate Medicare and Medicaid by allowing integrated acute and long-term care for dual-eligibles through Special Needs Plans; streamlining Medicare financing rules; and allowing automatic enrollment in integrated programs with an opt-out option.	Page 5: Integrated long-term care Page 5: Coordinated care networks Page 5: Consumer-directed care
Program Administration	Framework for Program Administration	121	Tony McCann	Construct a new framework for managing the Medicaid program that will reflect changes made in the DRA to the acute care benefits in Medicaid for healthy low-income individuals and families. Reorganize program into three separate components: Acute and Preventive Care Benefits Package; Long Term Care and Supports Benefit Package; and Subsidized Coverage for the non-Medicaid uninsured.	Page 3: Fiscally responsible system Page 3: Flexible benefit design Page 5: Consumer-directed care Page 6: Flexible benefits Page 6: Premium components

CATEGORY	TITLE/ THEME	PAGE IN FULL CATALOG	SUBMITTED BY	SUMMARY	CROSS-REFERENCE TO "MEDICAID: NEW VISION, REAL CHANGE"
Quality/IT	Quality-Related Technology Incentives	54	Mark de Bruin	Provide for enhanced Federal Medical Assistance Percentage for Medicaid to states that adopt new information technologies to support e-prescribing, disease management, management therapy management, and or drug utilization review efforts.	Page 1: Patient-centered system Page 2: Prevention-focused system Page 2: Outcome-oriented system Page 3: Measurement of results Page 4: Health literacy Page 4: Financial incentives Page 5: Measurement of outcomes Page 6: New forms of service delivery
Quality	Wellness and Prevention Incentives	104 - para. 2	Robert Helms and Grace-Marie Turner	Construct creative funding mechanisms to offer incentives for patients and health plans to encourage wellness and prevention through healthy behaviors.	Page 1: Patient-centered system Page 2: Prevention-focused system Page 2: Outcome-oriented system Pages 2-3: Market-based system Page 4: Health literacy Page 4: Ability to earn benefits Page 4: Financial incentives Page 5: Measurement of outcomes
Program Administration	Eliminate Disincentives for States to Implement Managed Care Models	131	John Monahan	Count Medicaid managed care inpatient days for purposes of calculating Upper Payment Limit.	Page 3: Market-based system Page 3: Fiscally-responsible system Pages 5, 6: Premium-based financing Page 5: Managed care Page 6: Value-based competition
Long Term Care	Improving Access to LTC Services	155	John Rugge	Improve the continuum of long term care by increasing institutional diversion and home- and community-based care where appropriate; further curbing inappropriate estate planning; providing incentives like asset-protection for long-term care insurance; and providing incentives for using reverse mortgages.	Page 1: Patient-centered system Pages 2-3: Market-based system Page 3: Fiscally responsible system Page 5: Integrated home- and community-based services