

Medicaid Best Buys: Promising Reform Strategies for Governors

By *Melanie Bella, Stephen Goldsmith, and Stephen A. Somers*

Time and time again, states have demonstrated, in the words of Justice Brandeis, that they are the nation's "laboratories for innovation," and Medicaid is one of the best opportunities for innovative leadership in the state policy arena. Medicaid serves 55 million Americans — 40 percent of our newborns, one third of our children, a disproportionate number of our racially and ethnically diverse citizens, most of those with disabilities, and many of our frailest seniors. The nation should get the highest quality and the best value for every health care dollar it spends — including the \$330 billion spent in 2005 on Medicaid and the State Children's Health Insurance Program (SCHIP).

While external factors — ranging from the reauthorization of SCHIP in 2007 to developing solutions to covering the uninsured — will inevitably put pressure on states, Medicaid has ample opportunities to lead through innovative care management approaches that address the complex and costly health needs of its most vulnerable members. Improving the way care is delivered in Medicaid will not only target scarce public resources more effectively, it can also spill over to improve health care delivery as a whole, for state employees, retirees, and commercially insured populations. This analysis of Medicaid "Best Buys" outlines five of the most promising opportunities for improving the health of high-risk and high-cost Medicaid beneficiaries while slowing the rise in spending.

The growth in Medicaid spending is viewed by some as unsustainable. But efforts to curb that growth must recognize that Medicaid serves as: (1) the health care safety net for the increasing numbers of people losing employer-based insurance; (2) the primary source of revenue for safety-net institutions for the uninsured; and (3) the funder of last resort for long-term supports and services for people with disabilities and the frail elderly. Increasingly, policymakers are realizing that short-term fiscal fixes — cutting rates, coverage, or benefits — simply shift the costs to other payers (e.g., hospital uncompensated care pools) or to another day when people with preventable (and costly) health needs present themselves for publicly financed care.

The alternative for innovative state leaders is to pursue opportunities to get better value for every taxpayer dollar spent for Medicaid and to "bend the trend" in longer-term cost growth. In every state, a very small proportion of beneficiaries account for the bulk of Medicaid's expenditures. Up to 80 percent of spending is on approximately 20 percent of enrollees, primarily those with severe chronic illnesses and disabilities and the frailties associated with aging. By examining patterns of illness in their Medicaid populations, states can target opportunities to achieve both short- and long-term returns on investment in health care quality improvement.

Many state Medicaid agencies and their health plan contractors are already identifying high-risk, high-cost populations and coordinating their care more efficiently and effectively through care management programs. These Medicaid stakeholders are succeeding in improving quality for patient populations for whom there are likely to be quicker returns on investment — i.e., high-risk pregnant women, children with serious asthma, and adults with congestive heart failure. This should help them convince other state policymakers, including governors, legislators, and budget directors, to invest in longer-term quality improvement initiatives for other populations, such as those with diabetes, depression, and other combinations of chronic conditions. What follows is a five-part strategy for state leaders to consider as they face opportunities within Medicaid to both "do good and do well."

Issue Brief

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This brief outlines a five-part strategy to help states improve health care quality for Medicaid's most chronically ill and costliest beneficiaries and curb increases in spending.

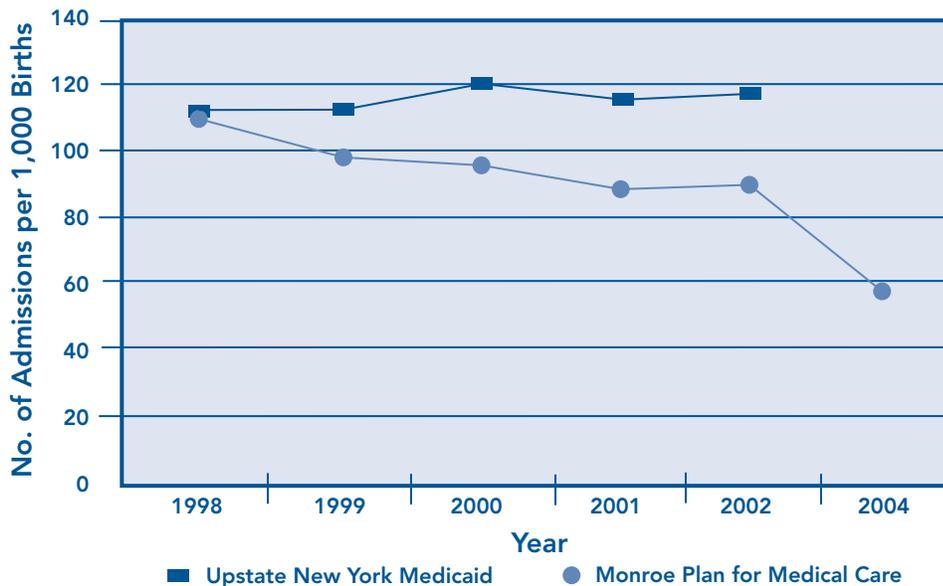
Five-Part Strategy for Medicaid Reform

1. Care Management Program for High-Risk Pregnancy

Policy Rationale: Medicaid covers up to half of all births in this country, thus accounting for a significant percentage of total Medicaid inpatient admissions. Hospital charges for a normal birth-weight baby average \$5,800,¹ whereas a low-weight infant in need of intensive care can cost \$1 million or more. Women from lower socioeconomic groups experience poorer birth outcomes than other mothers, putting Medicaid at risk for higher delivery claims and neonatal intensive care unit (NICU) expenses. Therefore, enhancing the potential for healthier newborns is a major opportunity for return on investment.

Managed care initiatives aimed at increasing the number of healthy births have substantially reduced NICU admission rates and have had positive returns on investment. For example, by improving its prenatal outreach program for Medicaid members, the Monroe Plan, a non-profit managed care organization in Rochester, New York, dramatically reduced NICU admissions, saving \$2 for each dollar invested in the program.²

Neonatal Intensive Care Unit Admission Rates for Monroe Plan for Medical Care and Upstate New York Medicaid



Source: Stankaitis et al., "Reduction in Neonatal Intensive Care Unit Admission Rates in a Medicaid Managed Care Program." *American Journal of Managed Care*, May 2005; 11:166-172.

Recommendation:

- Implement a statewide program to reduce NICU admissions for high-risk pregnant women, including incentives for plans and providers to implement prenatal care outreach programs for high-risk pregnancies.

¹ K.D. Cuevas, D.R. Silver, D. Brooten, J.M. Youngblut, C.M. Bobo, "The Cost of Prematurity: Hospital Charges at Birth and Frequency of Rehospitalizations and Acute Care Visits over the First Year of Life: A Comparison by Gestational Age and Birth Weight," *American Journal of Nursing*, July 2005, 105 (7): 56-64.

² J.A. Stankaitis, H.R. Brill, and D.M. Walker, "Reduction in Neonatal Intensive Care Unit Admission Rates in a Medicaid Managed Care Program." *American Journal of Managed Care*, May 2005; 11:166-172.

2. Care Management Program for High-Risk Asthmatic Children

Policy Rationale: Medicaid provides care for one third of all children in the United States. Asthma care for children drives up costs considerably; approximately 12 percent of children in Medicaid are diagnosed with asthma with estimated costs for their care surpassing \$16 billion annually.³ Asthma accounts for 14 million lost school days for children and 14.5 million lost work days for adults.⁴

Care management for children with severe asthma can reduce the incidence of asthma attacks and keep children out of emergency rooms and hospitals. By targeting high-risk cases and creating financial incentives to reward improved care management, states can achieve significant savings. Several states, including California, New York and Arkansas, have demonstrated the substantial reductions in hospital-based care that can be achieved through targeted asthma interventions. For example, in California, 11 Medicaid health plans participating in a collaborative to improve asthma care observed a 21 percent decrease in asthma-related emergency department visits and a 35 percent decrease in asthma-related hospital admissions over two years.

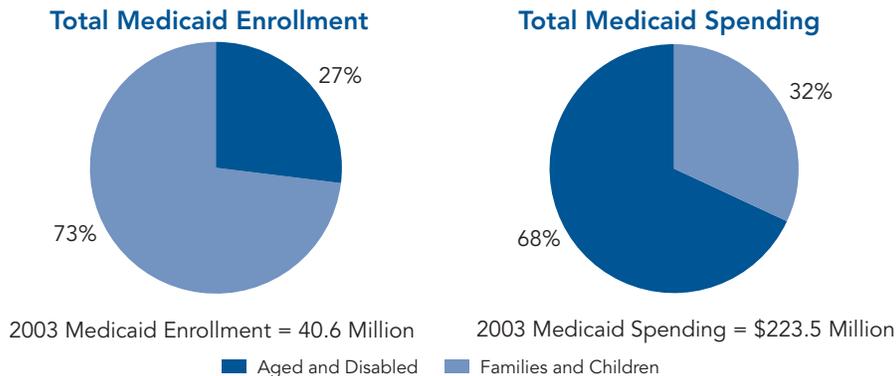
Recommendation:

- Enroll high-risk children with asthma into care management programs, with appropriate financial incentives, operated either by the state, health plans, or care management organizations.

3. Managed Care Models for Aged, Blind, and Disabled Medicaid Beneficiaries

Policy Rationale: Aged, blind, and disabled beneficiaries make up only 27 percent of Medicaid enrollees, but their care accounts for close to 70 percent of total Medicaid spending. Most of these beneficiaries are in unmanaged fee-for-service settings, with little to no coordination of their complex array of health care needs. Based on positive experiences managing care for “healthier” TANF populations (moms and kids) — the majority of whom are in managed care — states are recognizing opportunities to improve health outcomes, quality of life, and value for tax dollars by coordinating care more effectively for aged, blind, and disabled beneficiaries. Although there are challenges to enrolling the aged, blind and disabled population into managed care, states are using a variety of models, including enhanced primary care case management and comprehensive care management, to provide higher levels of care coordination for beneficiaries with chronic needs.

Medicaid Enrollment and Spending by Population



Source: Holahan and Ghosh, “Understanding the Recent Growth in Medicaid Spending, 2000–2003.” *Health Affairs*, January 2005.

³ National Institutes of Health and National Heart, Lung and Blood Institute, “Morbidity & Mortality: 2004 Chart Book on Cardiovascular, Lung, and Blood Diseases,” May 2004: 17. http://www.nhlbi.nih.gov/resources/docs/04_chtbk.pdf.

⁴ K.B. Weiss, et al., “An Economic Evaluation of Asthma in the United States,” *The New England Journal of Medicine*, March 1992, 326 (13):862-6.

Managed care programs for aged, blind, and disabled beneficiaries can improve health outcomes, control costs, and provide a measure of budget predictability to the state. For example, CareOregon, a Medicaid managed care plan, implemented a case management program for high-risk aged, blind, and disabled Medicaid members that succeeded in reducing claims costs by approximately 50 percent compared to costs for similar high-risk members who were not case managed. Other states, such as Pennsylvania and Washington, are implementing promising state-based care management approaches.

Recommendations:

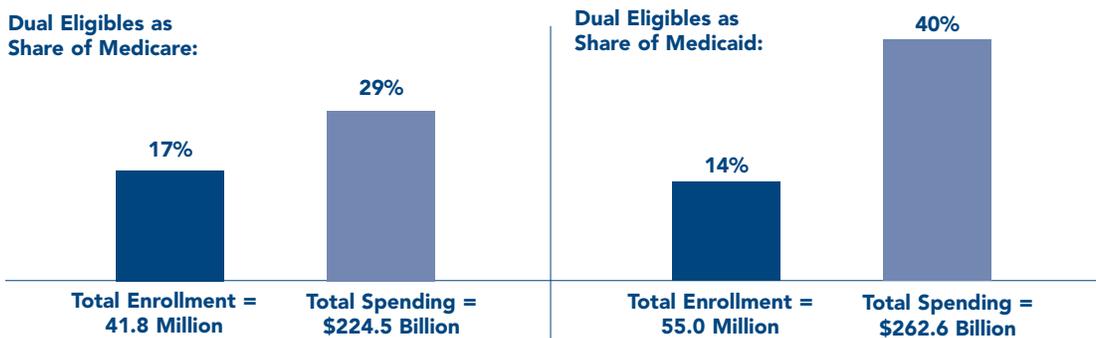
- Ensure that aged, blind, and disabled beneficiaries are enrolled in one or more models of managed care:
 - Full-risk or partial-risk capitation through a contract with a health plan.
 - Case management fee arrangement with a health plan, care management organization, or provider.
 - Partial-risk to non-risk arrangement through a contract with an administrative services organization.

4. Managed Care Models for Long-Term Care Supports and Services

Policy Rationale: Medicaid pays for nearly 50 percent of the nation’s total spending on long-term care, creating a significant incentive for states to better manage the long-term care needs of Medicaid beneficiaries, including those who are also eligible for Medicare (the “dual eligibles”). These options include programs that manage long-term supports and services only, those that integrate acute and long-term care, and, ultimately, those that integrate Medicaid and Medicare.

Though not without its challenges, the biggest opportunity lies in improving care for the seven million dual eligibles, who represent only 14 percent of Medicaid’s enrollment but drive over 40 percent of total Medicaid expenditures. Close to 70 percent of those expenditures are for long-term care, reinforcing the importance for states of actively managing long-term care supports and services and to integrate them with primary, acute, and behavioral services. Minnesota, through its Senior Health Options program that integrates Medicare and Medicaid services, significantly reduced the number of preventable hospital and emergency room admissions for enrollees residing both in nursing facilities and the community.

Dual Eligibles as a Share of Medicare and Medicaid Enrollment and Spending, 2002-2003



Source: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

States not ready to fully integrate Medicaid and Medicare services can still reap benefits by developing programs to better manage long-term care services and supports and integrate long term and acute services. Managed long-term care programs have been shown to improve quality, cost-effectiveness, and community placements in several states, including Arizona, Florida, Texas, and Wisconsin.

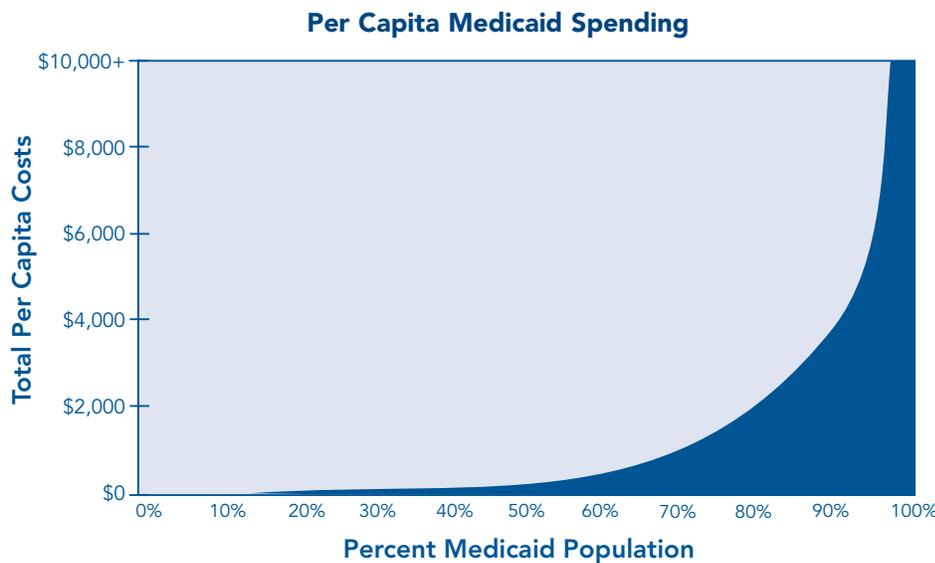
Recommendation:

- Implement a managed long-term care program for Medicaid beneficiaries.
- Implement a managed long-term care program for Medicaid beneficiaries that also integrates acute care services covered by Medicaid.
- Implement an integrated care program for dual eligibles with one of the following approaches:
 - Wraparound or partially capitated contract for one or all of the services covered by Medicaid (e.g., non-covered Medicare acute care services and drugs, behavioral health, care management, personal care services, nursing facility, and home- and community-based services).
 - Capitated contract with a Medicare Advantage Special Needs Plan for the full range of Medicaid services (e.g., primary, acute, behavioral, long-term care supports and services).

5. Care Management for High-Risk, High-Cost Members with Multiple Chronic Health Needs

Policy Rationale: The majority of Medicaid beneficiaries are relatively inexpensive, with a remarkably small number of beneficiaries driving a significant portion of total spending. Less than 5 percent of Medicaid beneficiaries account for close to 50 percent of total expenditures, with the top 1 percent responsible for over 25 percent of annual Medicaid costs nationally.⁵ Most of these beneficiaries have multiple chronic physical and behavioral health conditions and/or disabilities, often further complicated by difficult socio-economic factors. Developing programs to better manage the care of this very small, high-cost group of beneficiaries offers tremendous opportunities to increase quality and control costs.

By using predictive modeling to identify patients who may become ill (and costly) and employing intense medical management for those with multiple diseases who are already very costly, some organizations have shown a significant decrease in cost and improvement in quality measures. By reducing the need for, and utilization of, hospitals and nursing homes, costs for these patients can eventually be brought under much better control.



Source: Sommers A. and Cohen M. *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

Recommendations:

- Implement a care management program that focuses on the top 1 to 5 percent of highest-risk, highest-cost beneficiaries.
- Incorporate a targeted care management strategy for the top 1 to 5 percent of highest-risk, highest-cost beneficiaries into any managed care program or contract for aged, blind, and disabled beneficiaries.

⁵ Agency for Healthcare Research and Quality, "AHRQ Annual Report on Research and Financial Management, FY 2001," <http://www.ahrq.gov/about/annrpt01/annrpt01.pdf>.

About the Authors

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About The Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, providers, and consumers to design programs that better serve high-need and high-cost populations. Its program priorities are: improving quality, reducing racial and ethnic disparities, and integrating care.

About the Government Innovators Network

The Government Innovators Network (www.innovations.harvard.edu) is an online marketplace of ideas and examples of government innovation for policy makers, policy advisors, and practitioners. It strives to stimulate new ideas and bring people and ideas together around innovations in governance. The Government Innovators Network was developed at the Roy and Lila Ash Institute for Democratic Governance and Innovation at the John F. Kennedy School of Government at Harvard University. The Ash Institute also administers the Innovations in American Government Awards Program. The Program identifies and promotes best practices and exemplary projects that can be adopted in other settings, providing public officials and senior executives with innovative leadership models.

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Resources for State Government Officials

Seeking Higher Value in Medicaid: A National Scan of State Purchasers — This CHCS report provides a comprehensive look at the current Medicaid managed care environment from the perspectives of 14 states — California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin. Interviews with Medicaid directors and staff in these states offer valuable insights about states' plans for expanding managed care, promising practices for improving quality through value-based purchasing, and innovative trends in the Medicaid managed care marketplace. The report is available at www.chcs.org.

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