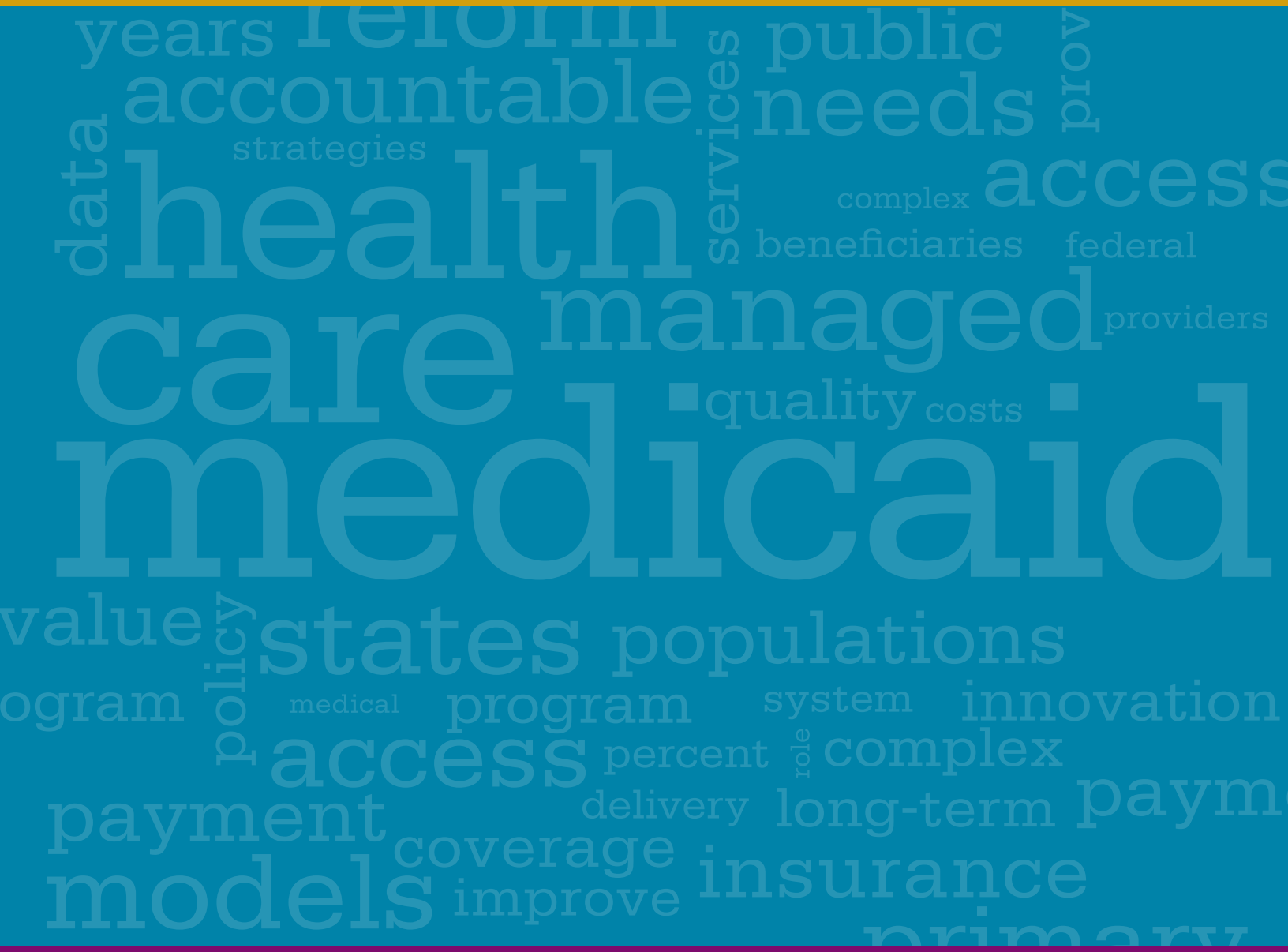
Toward 2014: Perspectives on Shaping Medicaid's Future



CHCS Center for Health Care Strategies, Inc.

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PREFACE

In 1995, the Robert Wood Johnson Foundation (RWJF) launched the *Medicaid Managed Care Program* (MMCP) to help state Medicaid agencies and their health plan partners explore the new frontier of managed care. Back then, states were looking to invest public dollars more prudently and improve health care for not quite 40 million Medicaid beneficiaries. As MMCP's national program office, the Center for Health Care Strategies (CHCS) coordinated a wide range of technical assistance activities aimed at: (1) helping states become effective purchasers of managed care; (2) assisting health plans in improving quality; and (3) supporting new delivery models for Medicaid beneficiaries with complex conditions.

Along the way, Medicaid programs have evolved markedly, the number of beneficiaries served and dollars spent have increased exponentially, and CHCS has cemented productive relationships with Medicaid stakeholders across the country.

To mark the conclusion of MMCP, CHCS asked Medicaid thought leaders to reflect on lessons from the past two decades and consider the implications for Medicaid's future.

We are grateful for RWJF's visionary leadership and willingness to make a substantial long-term investment in this bedrock of the nation's health care system. That investment has helped shape and strengthen the Medicaid delivery system and has positioned states to take on an increasingly central role in providing vital services for millions more Americans.

Stephen A. Somers, PhD, President

INTERVIEWEES

We are grateful to our interviewees who represent a broad array of perspectives from all corners of the nation's evolving Medicaid program. Their contributions offer invaluable insights for the future of the publicly financed health care delivery system.

- **Sanjeev Arora, MD,** Director, Project ECHO, University of New Mexico Health Sciences Center
- **Deborah Bachrach, JD,** former New York Medicaid Director and current Partner, Manatt, Phelps & Phillips
- **Richard J. Baron, MD,** President-elect, American Board of Internal Medicine
- **Melanie Bella,** Director, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services
- **Robert Blendon, ScD,** Senior Associate Dean for Policy Translation and Leadership Development, Richard L. Menschel Professor of Public Health and Health Policy, Harvard School of Public Health
- **Dan Crippen, PhD,** Executive Director, National Governor's Association
- **Toby Douglas, MPH, MPP,** Director, California Department of Health Care Services
- **Arnie Epstein, MD,** Professor of Health Policy and Management, Harvard School of Public Health
- **Foster Gesten, MD,** Medical Director, Office of Quality and Patient Safety, New York State Department of Health
- **Marsha Gold, ScD,** Senior Fellow, Mathematica Policy Research
- **Darin Gordon,** Deputy Commissioner, TennCare
- **Robert Hurley, PhD,** Professor Emeritus, Medical College of Virginia, Virginia Commonwealth University
- **Tom Kelly,** former President and Chief Executive Officer, Aetna Medicaid
- **Coleen Kivlahan, MD,** Senior Director, Health Care Affairs, Association of American Medical Colleges, and practicing primary care physician
- **Chris Koller,** Health Insurance Commissioner, State of Rhode Island Office of Health Insurance
- **David Labby, MD,** Chief Medical Officer, Health Share of Oregon
- **Bob Master, MD,** Chief Executive Officer, Commonwealth Care Alliance
- **Sara Rosenbaum, JD,** Professor of Health Law and Policy, George Washington University School of Public Health and Health Services
- **Matt Salo,** Executive Director, National Association of Medicaid Directors
- **Jim Verdier, PhD,** Senior Fellow, Mathematica Policy Research

TOWARD 2014: PERSPECTIVES ON SHAPING MEDICAID'S FUTURE

41%

Births covered by Medicaid

1 in 3

Children covered by Medicaid

Introduction

Congress and President Obama made an explicit choice in framing the Affordable Care Act (ACA) to position Medicaid, as opposed to Medicare, as the foundation for universal coverage in this country. A little more than 15 years earlier, it would have been inconceivable to seriously consider Medicaid for this central role in undergirding the U.S. health care system. Today, through the addition of the Children's Health Insurance Program and the delinking of Medicaid from welfare, as well as the strides that state Medicaid agencies and their health plan partners have made, the Medicaid infrastructure is far more able to take on this expanded role.

More and more Americans now realize that Medicaid is not a welfare program for the poor, perpetuating dependency on federal dollars. To the contrary, Medicaid provides health insurance and access to health care for those without access to private insurance. Medicaid is for our neighbors who have lost their jobs and have children with common chronic illnesses like asthma or more disabling conditions like autism or cerebral palsy. It is for retirees who are diagnosed with Alzheimer's far too early in their "golden years" and spend down their savings on needed long-term services and supports. It is for our single adult cousin with multiple sclerosis and chronic diabetes who has a part-time job at a local non-profit library, which cannot afford to provide health care coverage.

> *Medicaid does matter — it now touches more of our neighbors as well as many of our older family members needing long-term care. On the positive side, it is no longer considered welfare for undeserving people. On the negative, it is also now perceived by many as a budgetary Pac-Man.*
>
> —**Robert Blendon, ScD**, Senior Associate Dean for Policy Translation and Leadership Development, Richard L. Menschel Professor of Public Health and Health Policy, Harvard School of Public Health

The public increasingly understands the value of Medicaid for its relatives, friends, and neighbors. At the same time, it can also see that health care costs are threatening to swallow up state and federal budgets. This has driven some policymakers to seek greater reliance on the private insurance market for serving the ACA's Medicaid expansion population. Reform of Medicaid financing and other policy changes are inevitable. Our interviewees agree, but join us in hoping to preserve the fundamental elements of the program, especially a broadened entitlement to a floor of basic health benefits.

> *Medicaid as a purchaser provides someone who is very poor with some small amount of clout in the system, which they would otherwise be unable to leverage. Medicaid is responsible for the quality of health care provided to the poor.*
>
> —**Sara Rosenbaum, JD**, Professor of Health Law and Policy, George Washington University School of Public Health and Health Services

While Medicaid stakeholders have long believed in the value of Medicaid coverage, recent studies confirm that Medicaid coverage indeed makes a difference. When Oregon held a lottery to award a limited number of Medicaid slots in 2008, the state became a natural laboratory for assessing the impact of providing health coverage for low-income, uninsured individuals.[1] Although this unprecedented study showed no statistically significant improvements in physical health outcomes after two years, those with Medicaid coverage did have increased access to and use of care, lower rates of depression, decreased out-of-pocket costs, and reduced medical debt. A look at Medicaid expansion programs in Arizona, Maine, and New York, confirmed that not only did Medicaid improve health status, but it also saved lives — with one saved for every 176 enrolled.[2]

43%

Long-term care costs in the U.S. covered by Medicaid

1:176

For every 176 people enrolled in Medicaid, roughly 1 life is saved

Those without insurance get much poorer care than those with Medicaid insurance.

—**Sanjeev Arora, MD**, Director, Project ECHO, University of New Mexico Health Sciences Center

Medicaid also works in terms of helping to provide high quality care at low-budget costs. As a public program with limited dollars, Medicaid has always had to be cost conscious. Although Medicaid consumes roughly 23 percent of state budgets and eight percent of federal outlays, state programs have maximized the use of resources.[3,4] Administrative overhead for the program is under seven percent compared to nearly 12 percent for private coverage.[5] Per capita cost growth for Medicaid is consistently lower than private coverage, averaging 2.8 percent annually for Medicaid from 2006–2011 compared to 4.2 percent for private insurance.[6]

Medicaid in many states is far beyond commercial purchasers — and even Medicare — as a purchaser in effective use of managed care.

—**Jim Verdier, PhD**, Senior Fellow, Mathematica Policy Research

Medicaid has come a long way, but still has far to go. Based upon a series of interviews with experts across the country, this synthesis explores how far Medicaid has come, why it currently matters more and more for millions of Americans, and where it must focus its efforts to improve in the years ahead.

I. FROM WELFARE TO HEALTH CARE: MEDICAID PARADIGM SHIFT

25%

Projected U.S. population covered by Medicaid by 2020, up from 15% in 2010

34/50

Number of states that currently do not offer Medicaid benefits to all childless adults under the federal poverty level

Reaching beyond what its original authors imagined at its enactment in 1965, Medicaid has taken on a far broader role in serving not only low-income Americans, but also adults and children with physical and developmental disabilities, those with serious mental illness, and frail elders. After mixed success in achieving its access-to-care goals through a traditional fee-for-service system, more widespread introduction of Medicaid managed care in the 1990s provided a critical new tool to help states ensure that more beneficiaries not only got covered, but also had access to timely, appropriate, and essential health care services.

Also in the 1990s, the Welfare Reform Act of 1996 delinked welfare and Medicaid eligibility, redefining Medicaid as a health care financing program. In some states, Medicaid's transition to a *health care* program tangibly manifested itself in the movement of Medicaid administration out of the social services department and into the department of health. In New York, becoming independent from welfare helped state Medicaid leadership evolve from a focus on writing checks and maintaining eligibility processes to pursuing improvements in health and health care delivery. In repositioning Medicaid apart from its welfare agency roots, states were able to channel more energy into innovative purchasing practices.

> *One of the big trends has been a major shift from thinking about Medicaid as a welfare program to thinking about it as a health care program.*
>
> —**Foster Gesten, MD**, Medical Director, Office of Quality and Patient Safety, New York State Department of Health

The delinking of Medicaid from welfare also helped diffuse the stigma around the program and make it more palatable for those eligible and the broader public alike. It helps that today nearly every American knows someone who has benefited from Medicaid coverage. Medicaid, once viewed as a marginal program, has grown considerably in popularity. A recent Kaiser Family Foundation poll found that 59 percent of Americans felt that Medicaid was important to them or their families, while only 13 percent supported major Medicaid program reductions.[7]

Although the full implications of the Welfare Reform Act's delinking of Medicaid from welfare in 1996 could not easily have been foreseen, it helped set the stage for the program's next major transformation as the platform for universal coverage of all low-income Americans under the ACA.

II. VALUE-BASED PURCHASING THROUGH MANAGED CARE

10%

Medicaid managed care enrollment in 1991

74%

Medicaid managed care enrollment in 2011

Medicaid managed care was not initially considered as a cost containment strategy; it was started to help ensure that everyone had access to a provider. It started fairly slowly, with some states, including Arizona and Tennessee, diving in and other states waiting for evidence from these early innovators. In 1992, 10 years after Arizona launched the country's first statewide Medicaid managed care program, only 12 percent of the nation's Medicaid population was enrolled in managed care. However, since then, Medicaid managed care enrollment, mainly for low-income parents and their children, rose precipitously, nearing 60 percent of beneficiaries by 2002.[8] Today, nearly 75 percent of Medicaid beneficiaries are enrolled in managed systems of care, including managed care organizations as well as primary care case management approaches.[9]

> *Increasing access to care for Medicaid beneficiaries by fiat — through managed care contracting — has been an unequivocal win.*
>
> —**Robert Hurley, PhD**, Professor Emeritus, Medical College of Virginia, Virginia Commonwealth University

With the increase in managed care enrollment, states have pursued progressively more sophisticated models to improve access, accountability, and quality and hold down costs.[10] As Medicaid managed care evolved, the role of states shifted from bill payer — simply dispensing provider payments on a fee-for-service basis — to sophisticated purchaser — leveraging buying power to improve care and reduce costs.

> *Medicaid managed care utterly changed the program to move Medicaid in the same direction that employers were moving in.*
>
> —**Sara Rosenbaum, JD**, Professor of Health Law and Policy, George Washington University School of Public Health and Health Services

States have been creative in testing new performance measurement, payment, and contracting strategies to drive improvements in the quality of care. Early pay-for-performance approaches to align payment with quality for Medicaid health plans and providers have presaged today's new array of value-based purchasing strategies, such as global payment, bundled payment, and shared savings mechanisms.

> *Medicaid managed care helped shift the program's role from that of an insurance company that pays bills, to an entity that actively thinks about its role and responsibility as a purchaser to improve population health, individual outcomes, and keep an eye on costs.*
>
> —**Foster Gesten, MD**, Medical Director, Office of Quality and Patient Safety, New York State Department of Health

In adopting managed systems of care for Medicaid's relatively healthy populations — mothers and children — states have also become increasingly sophisticated at using managed care levers to improve health care access and quality and control costs for beneficiaries with more complex needs. Medicaid health plans, similarly, have increased their capacity to identify patients at risk and create tailored quality improvement activities for them.

> *Medicaid managed care has been forced to be innovative because the level of need of the population it serves demands more radical approaches.*
>
> —**David Labby, MD**, Chief Medical Officer, Health Share of Oregon

Medicaid stakeholders must continue to foster innovation and push accountability. A recurring theme of our interviews was that many managed care stakeholders were at risk of "plateauing" in terms of driving for greater value.

There is enormous pressure for programs to generate savings with a one-year budget cycle. It ends up being a technical and a leadership challenge to drive improvements that can continue to have longer-term payoffs.

—**Chris Koller**, Health Insurance Commissioner, State of Rhode Island Office of Health Insurance

Some states are beginning to think creatively about using new managed care "pressure points" to drive quality rather than quantity. States are exploring new bundled payment strategies (e.g., Arkansas); building further incentives into capitated rates (e.g., Texas); using contracting strategies to support patient-centered medical homes (e.g., New York); and integrating ACA reforms (e.g., accountable care organizations [ACOs], health homes, etc.)

FROM CARVE-IN TO CARVE-OUT AND BACK: AN EXAMPLE OF ONE STATE'S EVOLUTION

"TennCare was a poster child for everything that could go wrong in managed care," notes Darin Gordon, Tennessee's Medicaid director, about the state's initial roll-out of managed care in 1993. According to Gordon, many in the state believe that it dove into managed care somewhat blindly, perhaps overly ambitious about potential savings. TennCare's first managed care iteration was all encompassing — moving their entire existing population into full-risk managed care, while expanding Medicaid coverage to new populations and carving in pharmacy, behavioral health, and dental services. Enrollment swelled from 800,000 to 1.2 million in under one year.

"Early on, TennCare may have served as the poster child for what not to do, but today the state is heralded as a leader for its well-designed managed care approach."

Other states, Medicaid policymakers, and foundations viewed Tennessee's ambitious move with a mix of skepticism and admiration. The ultimate notoriety of Tennessee's bold and brash experiment drove greater federal oversight of state managed care demonstrations as well as major philanthropic investments — such as RWJF's Medicaid Managed Care Program — to help states engage in more strategic, long-term planning around managed care program design and implementation.[1]

A number of lawsuits and detractors caused Tennessee to rethink its initial managed care roll-out. Over a period of several years, enrollment was closed to certain groups, some services were carved out, and the state assumed financial risk from the managed care organizations. After obtaining relief from certain lawsuits and informed by the program's prior experience, the state then launched a new, full-risk, integrated managed care model with a phased-in implementation. Lessons from TennCare's early experiences have guided the state's efforts to:

- ***Build a more sophisticated skill set.*** As Medicaid moved into a regulator/compliance role, it needed to hire and train staff who knew how managed care worked and could help plans succeed. The 12 plans that initially contracted with TennCare were not equipped to handle risk. "We know now that it's not just the plan's problem — it's the state's responsibility," said Gordon. The move to a competitive procurement approach greatly facilitated the selection of experienced, high-performing health plans.
- ***Use data strategically.*** "When I got pulled into the bureau in 2002 my first focus was to find a way to avoid flying blind," said Gordon. The state moved from an environment where it waited six months for data reports, to a culture hungry for data to guide decision-making.
- ***Define new vision for state/plan relationship.*** Tennessee recognized that adversarial relationships were not conducive to solving problems and that it had to forge productive partnerships, particularly with its plans, while maintaining the leverage inherent in its purchasing authority.
- ***Think innovatively, but take time to do so.*** The innovation engine should never be shut down, but TennCare's speedy roll-out is not advisable. As Gordon observed, "we ended up spending the next 10 years fixing the program because the foundation was pieced together too quickly."

While early on, TennCare may have served as the poster child for what not to do, today the state is heralded as a leader for its well-designed managed care approach. TennCare is one of the few state programs that has fully integrated behavioral health and long-term services and supports into its managed care delivery system. The program has a sophisticated data dashboard designed to monitor program performance, identify gaps, and stratify populations to pinpoint areas for improvement. Notes Gordon, "Our cost growth is the lowest in the country, our quality indicators are continuously increasing across the board — managed care can work."

1. Firshein J, and Sandy LG. "The Changing Approach to Managed Care." *To Improve Health and Health Care*, Jossey-Bass, 01/01/2001

into their managed care delivery systems (e.g., Colorado, Minnesota, Oregon, etc.). States can help engineer cross-payer partnerships that provide enhanced primary care reimbursement. New York's Adirondack Regional Medical Home Pilot, for example, is offering providers increased reimbursement for expanded responsibility for coordinating care, providing preventive care and managing chronic diseases. As noted by one of our interviewees, there is still "lots of juice left in the squeeze" for more informed purchasing, particularly for high-cost, high-need populations — the question is how to continue tapping that potential.

> *There has been a big push in states toward trying to medically manage their neediest and most complex patients. This really challenges states' ability to manage the managers.*
>
> —**Dan Crippen, PhD**, Executive Director, National Governor's Association

Finding, developing, and retaining the managers to ensure that Medicaid's knowledge base is up to the task is difficult given ongoing state hiring and salary freezes. Indeed, a recent NAMD survey of state Medicaid directors found that more than five percent of full-time positions in Medicaid agencies remained vacant in the last year with two states reporting more than 20 percent vacancies.[11] At the same time, many states have had to rethink the organizational structures and skill sets needed for their teams to support the shift to managed care. They need staff who can use data strategically to identify areas for improvement and design contracting strategies to advance quality goals.

Over the past 20 years states have grown considerably in their capacity to use data to monitor access, quality, risk, and outcomes, yet even so, there is more to be done to capitalize on the extractable data. Many interviewees acknowledged the need to use data more strategically to support value-based purchasing. States like New York, Tennessee, and Washington, are creatively leveraging state data analytic teams to inform how to invest Medicaid funds more efficiently.

> *It's not good enough to just get data, states need to have the wherewithal to make good use of their data.*
>
> —**Darin Gordon**, Deputy Commissioner, TennCare

Using data strategically may help uncover unmet needs. Leading states are exploring new ways to use data to identify at-risk populations before they end-up in the hospital or in need of long-term care. States and plans are using predictive modeling approaches to target individuals at-risk for significant health issues *before* urgent situations (and avoidable costs) hit.

> *Underutilization is much more of an issue than overutilization among most Medicaid sub-populations. Fifty percent of Medicaid beneficiaries never see the doctor within a 12-month period. Are they avoiding medical care they really need or are they just really healthy people? When are these folks likely to get sick, and what is the downstream effect of the pent-up demand?*
>
> —**Coleen Kivlahan, MD**, Senior Director, Health Care Affairs, Association of American Medical Colleges, and practicing primary care physician

CULTIVATING MEDICAID THOUGHT LEADERS

As states expand coverage, build new models for complex need populations, spawn multi-payer delivery system innovation, and navigate new relationships with the ACA's insurance marketplaces, Medicaid directors need to be ready to lead. Yet, there is frequent turnover in Medicaid leadership positions, with the median tenure for Medicaid directors being only two years.[12]

The *Medicaid Leadership Institute* (MLI), a national fellowship program for Medicaid directors, funded by RWJF and run by CHCS, is helping them cultivate the skills necessary to transform their programs into national models for high-quality, cost-effective care. In the past year, MLI launched a new effort to help participating Medicaid directors "build the bench" of their senior leadership teams. The aim is to strengthen the decision-making and analytic skills of agency staff so that they can better support their state's overall Medicaid strategy.

III. RETHINKING CARE FOR COMPLEX AND HIGH-COST POPULATIONS

5%

of Medicaid beneficiaries account for

55%

of total Medicaid spending

Managing the care of high-cost Medicaid populations with multiple chronic conditions has never been more firmly in focus than it is today. Not only are the data telling the story about who the highest-need patients will be next year, but the pressure to ratchet down avoidable costs has never been higher. States know that less than five percent of their beneficiaries account for more than 50 percent of all costs.[13] These are precisely the patients whose care needs to be managed, yet they still remain the subset of the population most likely to be in unmanaged fee-for-service.

> *One of the biggest frustrations I face is caring for Medicaid and uninsured populations who have had little to no access to preventive services throughout their lives. So they end up with hypertension, congestive heart failure, diabetes — all preventable. By the time they come to me, all I can do is throw another drug at it.*
>
> —**Coleen Kivlahan, MD**, Senior Director, Health Care Affairs, Association of American Medical Colleges, and practicing primary care physician

States that have not already done so realize that they have to accelerate the move to managed care for their highest-cost populations. California's recent experience offers valuable guidance on rolling out managed care for adult Medicaid beneficiaries with disabilities. In 2011, California's Medi-Cal program transitioned 380,000 seniors and people with disabilities to mandatory managed care. Advocacy groups remain wary about the change, which highlights the importance of engaging consumers and providers early and often in reforms.

> *The biggest lesson for us in implementing mandatory managed care for seniors and persons with disabilities is how to better engage consumers and providers in delivery system reform so they can better understand the role and value of managed care. This lesson is critical as we move our dual eligibles into managed care.*
>
> —**Toby Douglas, MPH, MPP**, Director, California Department of Health Care Services

In transitioning Medicaid populations to managed care, states must remember to move slowly enough to solicit consumer feedback throughout the design and implementation process. Among other benefits, their input will help states and their delivery system partners determine the most important things to measure when monitoring program quality.

> *The kinds of consumer outreach that we're seeing now with the duals demonstrations would've been unheard of 20 years ago — it's time consuming, it's labor intensive, and it can lead you down a path of fundamentally changing what you had intended — but it's critical to get the consumer perspective on the table.*
>
> —**Matt Salo**, Executive Director, National Association of Medicaid Directors

In every state, a considerable portion of Medicaid spending is centered on Medicaid-only adults with serious mental illness. For patients with both physical and behavioral health conditions, health care costs are typically as much as 75 percent higher than for those without a mental illness.[14]

> *The lack of integration of physical health services with mental health, substance abuse, and long-term care services is absurd when we consider the complex needs of the population served by Medicaid.*
>
> —**Deborah Bachrach, JD**, former New York Medicaid Director and current Partner, Manatt, Phelps & Phillips

For individuals with serious mental illness, pilot efforts in states like Pennsylvania and Washington have begun to demonstrate successful approaches for integrating services. These efforts are improving appropriate access to care and reducing preventable hospital and emergency room visits. More than half of all states are looking to capitalize on the ACA's health homes to expand these types of integrated models statewide.

15%➔40%

Adults who are eligible for Medicare and Medicaid make up 15% of Medicaid beneficiaries, but incur 40% of Medicaid costs

75%

Medicaid beneficiaries with physical and behavioral health conditions cost on average 75% more than those without behavioral health conditions

Complex populations exist in both the Medicaid-only and dual population. But what we see around the country today is that they are often treated as separate populations to be handled differently.

—**Bob Master, MD**, Chief Executive Officer, Commonwealth Care Alliance

Those who are dually eligible represent only 15 percent of Medicaid beneficiaries yet almost 40 percent of Medicaid costs.[15] These populations receive a complex array of acute and long-term services and supports, yet in most states, their care is still uncoordinated with little to no communication or collaboration across providers. Despite dual eligible status being often associated with elderly beneficiaries, nearly 38 percent of those dually eligible for Medicare and Medicaid are non-elderly adults with disabilities.[16] For both groups, the federal duals demonstration project has helped accelerate the development of integrated care models by addressing financial and other program misalignments between Medicaid and Medicare that have historically posed barriers to integration. California, Illinois, Massachusetts, Ohio, and Washington are the first states to gain the Centers for Medicare & Medicaid Services' (CMS) approval to move forward with their integration models for duals, with other states soon to follow.

Even if states cannot fully integrate Medicare and Medicaid for their seniors and people with disabilities, they have to improve the management and delivery of programs for long-term services and supports. Medicaid now accounts for 43 percent of all long-term care spending in the U.S., making it the primary payer for these services.[17]

Over the past 20 years, we keep having the same conversation: "How can we cover more people in the long-term care benefit?" I fundamentally think that's an unsustainable position to take. Pregnant women and children aren't bankrupting Medicaid — long-term care is."

—**Matt Salo**, Executive Director, National Association of Medicaid Directors

Managed care can help better coordinate long-term services and supports, and keep costs in check as the need for services expands with the aging baby boom population. By 2014, an anticipated 26 states will have established managed long-term services and supports (MLTSS) programs.[18]

Tennessee implemented its MLTSS program in 2010, and established mandatory enrollment for elderly and disabled beneficiaries using nursing facilities, in need of nursing home level of care, or at-risk of institutionalization. To avoid further fragmentation, the state developed its MLTSS program within the existing managed care delivery infrastructure of its Medicaid program, TennCare.[19] The state contracted with its plans to expand access to home- and community-based services and built strong consumer protections into the program.

The inadequacy of performance measures for Medicaid populations with complex needs — both acute and long-term care — is a serious impediment to progress. If states are measuring the *wrong* things, they will not get the things done or convince consumers and providers that they know what they are doing in integrating care. Though measurement tools for managed care quality — such as the Healthcare Effectiveness Data and Information Set (HEDIS) — certainly exist, they are deficient in their capacity to assess the quality of care for complex populations.

Measuring best practices for integrating and coordinating person-centered care is challenging. We have a generic measurement system, but much work remains to be done to tease out what's important for specific populations.

—**Melanie Bella**, Director, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services

The logical progression of measurement development moves from testing, to quality improvement, to public reporting to incentivizing providers to adopt best practices for care delivery. For complex populations, however, the development of measures is still, for the most part, in the testing stage. This is a particularly acute problem for Medicaid given the prevalence of complex conditions among its beneficiaries.

IV. CONTRIBUTING TO DELIVERY REFORM ACROSS AND BEYOND THE HEALTH CARE SYSTEM

Under 1 in 3

Primary care physicians are willing to accept new Medicaid patients

7 to 11 million

Additional Americans will be eligible for Medicaid after 2014, pending state expansion decisions

The U.S. health care system needs radical transformation in order to achieve the Triple Aim of improved health, improved quality of care, and reduced costs.[20] Game-changing ideas at today's forefront include global payment, episode-based payment, and ACOs, many being propelled forward with ACA innovation resources.

> *The role of the federal government is critical for the advancement of Medicaid. First, the federal money is critical. Second, the federal government can be an obstacle if it is not supportive. Third, for states who are lagging in innovation and advancement, federal leadership is exceedingly important to nudge them along. Finally, the feds can serve as an engaged partner in regulation, infrastructure, and guidance for states.*
>
> —**Marsha Gold, ScD**, Senior Fellow, Mathematica Policy Research

Aligning these 'new ideas' with established systems (e.g., capitated managed care) may be challenging for Medicaid agencies to navigate, but some states are aggressively charging ahead. Arkansas is embarking on a dramatic shift in how it will pay for episodes of care. Colorado, Maine, Massachusetts, Minnesota, Oregon, Texas, and Vermont are among those forging ahead with broad-scale accountable care models, while New Jersey Medicaid is working to spread the very compelling "super utilizer" initiative in Camden.

The Camden Coalition of Healthcare Providers, an all-payer safety-net ACO, is widely recognized as a community-based model offering real promise for Medicaid populations. A Healthcare Innovations Grant from the Center for Medicare & Medicaid Innovation (CMMI) is supporting four cities — Allentown, Pennsylvania; Kansas City, Missouri; San Diego, California; and Aurora, Colorado — in establishing similar Sustainable High-Utilization Teams in their own regions. Similarly, RWJF's Aligning Forces for Quality program is supporting six regions — Boston; Cincinnati; Cleveland; Humboldt County, Calif.; Maine; and Western Michigan — in creating a network of community-based services to better address the needs of "super utilizers."

> *We need primary care investment and re-design on a scale that dwarfs what we have seen so far with patient-centered medical home initiatives. We need re-imagined primary care models for high-need populations along with robust primary care enhancement in order to make any real change.*
>
> —**Bob Master, MD**, Chief Executive Officer, Commonwealth Care Alliance

While serving Medicaid's highest-cost populations requires change at the state and health plan level, most fundamentally it is about delivery system changes — or reinforcements — that push care management resources to the point of care. This trend will force health plans to deploy their own resources in new and different ways. For people with developmental, intellectual, or physical disabilities, or serious mental illness, however, there is just not enough access to primary care that works in the current system. The situation is little better for frail elders with long-term care needs who become homebound or cognitively impaired. Social challenges inevitably compound these issues.

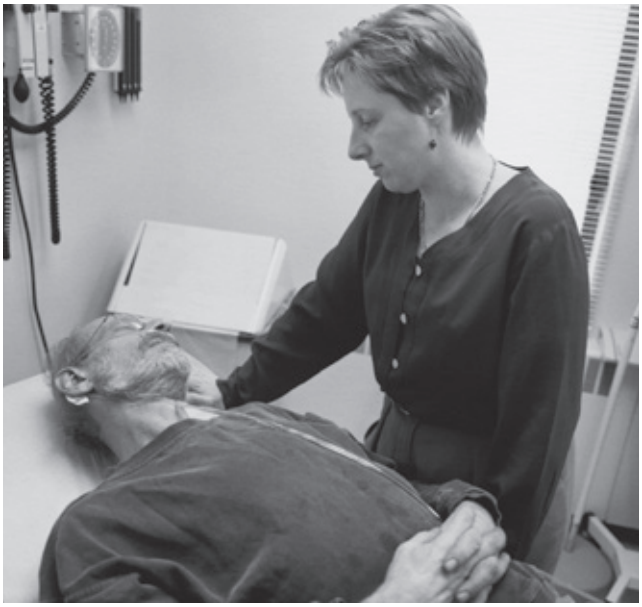
> *Complex populations in Medicaid often lie at the intersection of three compounding factors. They have complex health needs, they are poor, and they suffer from social deprivation, wherein they may lack transportation, stable housing, or family members to help care for them. Different parts of our system deal with these three issues separately and there is no coordinated way to bring these to a central point, which serves as the hub for a person's well-being.*
>
> —**Sanjeev Arora, MD**, Director Project ECHO, University of New Mexico Health Sciences Center

The ACA's health homes offer one vehicle that states can use to begin to change how primary care is delivered at the ground level, so that more holistic, complex care goes beyond the four walls of a physician practice. State agencies and Medicaid health plans need to consider how to support new kinds of providers, ranging from outpatient intensivists and

PROJECT ECHO — AMPLIFYING OPPORTUNITIES FOR HIGH-QUALITY CARE

Project ECHO, founded by Dr. Sanjeev Arora at the University of New Mexico, uses real-time virtual clinics to help community-based primary care providers enhance their capacity to manage illnesses like hepatitis C and diabetes by connecting them to hospital university specialists. The specialists are enthusiastic about sharing their expertise with community-based physicians to increase access to more routine specialty care, and to avoid making patients travel long distances to the academic health centers.

Under a CMMI grant and in partnership with a cadre of Medicaid health plans, Project ECHO will expand its innovative model to treat and manage the care of 5,000 high-cost, high-need Medicaid beneficiaries in New Mexico and Washington State. Project ECHO will train up to 100 providers, nurse practitioners, care managers, and community mental health workers to form outpatient intensivist teams to manage care for complex patients. The initiative is designed to increase primary care provider capacity, improve care for people with complex chronic conditions, and reduce unnecessary hospital admissions. Though the concept of care management for complex populations is not new, the Project ECHO model is unique in its ability to leverage the knowledge networks it has created through its virtual clinics to expand provider capacity for care management at the ground level.



community health workers to medical assistants and peer counselors. They also need to capitalize on the State Innovation Model (SIM) opportunities being funded by CMMI.

> *Theoretically, it is possible to have a win-win situation, where the feds, states, managed care organizations, and providers all benefit from the 'accountability dividend.' However, it is very hard to visualize the pathway that would get us there.*
>
> —**Tom Kelly**, former President and Chief Executive Officer, Aetna Medicaid

A fundamental question for states in exploring these new models is "who gets the accountability dividend?" States can assist health plans in determining how to structure contracting strategies with provider organizations to support a new enhanced primary care role. In terms of incentives for stakeholders in the health care system to do the 'right thing,' a common complaint among providers is that each payer is incentivizing them to do different 'right things' or to do the right things differently. There is certainly more and more lip service being paid to multi-payer alignment, but the evidence of the effectiveness has been slow to emerge. Medicaid, as an increasingly dominant purchaser, is well positioned to push forward on this agenda and is being invited to do so aggressively under the federal SIM initiative.

> *Managed care organizations need to pursue shared accountable contracting strategies with provider organizations. If they pursue different strategies within the same market, it can weaken the state's ability to drive delivery system transformation.*
>
> —**Richard J. Baron, MD**, President-elect, American Board of Internal Medicine

Moving forward into 2014, state Medicaid agencies that think about their programs in the broader context of the health care system will be better equipped to leverage purchasing influence, establish joint goals across the health care system, and reduce the negative consequences linked to the inevitable churn of beneficiaries across health coverage options. States can look to Oregon's experience through its newly created Coordinated Care Organization (CCO) for lessons on establishing a cohesive vision for health care delivery across the state. In Oregon, there were two key ingredients in place, policy leaders were shaping a new approach at

RHODE ISLAND'S MULTI-PAYER VALUE-BASED PURCHASING STRATEGY

Rhode Island has a cohesive long-term strategy to drive delivery system reforms that result in greater health care value. The value-based purchasing strategy, which leverages the state Office of Health Insurance Commissioner's authority over the health plans, is designed to achieve alignment across all payers, including commercial, Medicaid, state employee plans, as well as the new Rhode Island Health Benefits Exchange.

At the core, the state is using its rate review process to get health plans to focus on the true drivers of quality within the delivery system. Through an extensive stakeholder review process, the state identified four key areas that health plans must focus on to receive increased rates: (1) increase percentage of commercial medical payment going to primary care; (2) support and expand the state's all-payer medical home, the Chronic Care Sustainability Initiative; (3) maintain electronic health record adoption incentives; and (4) support hospital payment reform by including six contract elements in commercial contracts. By linking payment with a clear set of consistent standards, Rhode Island is furthering a unified vision necessary for more sustainable improvements in care delivery across the system.

the same time that the state's delivery system leaders were pushing forward new models in pockets across the state.

> *Oregon's CCO model probably wouldn't be there without the conversation that Medicaid has been having over the past 20 years in terms of how to improve accountability and rethink health care delivery. If there were no evidence that delivery system reform works, then it is unlikely Governor Kitzhaber would have proposed CCO transformation. We showed that innovative change can be done; now we're doing it on steroids.*
>
> —**David Labby, MD**, Chief Medical Officer, Health Share of Oregon

Today, there is a rush of new activity at both the state and federal level to improve care and curb costs, heightened through new ACA opportunities. The SIM initiative through CMMI, for example, is encouraging states to design and test comprehensive public/private payment and multi-payer delivery reform models that are integrated with housing, transportation, and other social services to improve public health, the quality of care and cost effectiveness.

> *The federal government can do some really great things 'behind the scenes' at the policy level to encourage positive changes in Medicaid, but ultimately they cannot build the capacity on the ground as high volumes of patients with complex needs are transitioned into new systems of care. States need to ensure that the right types of training, providers, and community-based structures are in place to implement policy change.*
>
> —**Melanie Bella**, Director, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services

It may be time to loosen our grip on the old saw: *If you've seen one Medicaid program, you've seen one Medicaid program*. Some regional variation is healthy, yet there are plenty of opportunities across states to achieve economies of scale in purchasing and contracting strategies. Among the recommendations proffered by our experts, a future Medicaid delivery system should foster more standardization. Some observers even suggested that it might be more efficient to have one federal purchaser rather than 50 separate purchasers. Although the economies of scale could be enormous, a federally run Medicaid program would lose the responsiveness to local system needs and dynamics. There are, however, steps that states and the federal government could take to standardize and increase cross-program and cross-system efficiencies without erasing the state and local character of health care delivery.

> *In 20 years, and perhaps even in the next decade, there's likely to be less variation and more standardization across state Medicaid programs and more federal responsibility. Priorities and values may differ by state, but evidence about what works do not. This doesn't mean the feds will run it, but the financial pressures of Medicaid will be such that governors will continue to ask for federal help.*
>
> —**Chris Koller**, Health Insurance Commissioner, State of Rhode Island Office of Health Insurance

V. CONCLUSION

The underlying evidence that Medicaid works has largely put to rest the argument that those with Medicaid are worse-off than those who have no insurance. It took Arizona 17 years to get a Medicaid program up and running after federal legislation was passed in 1965. Similarly, while it may take some time for states to accept the value of expanding Medicaid, most agree that all states will eventually opt for doing so, either through the traditional program or through greater reliance on the private market.

> *At the end of the day, economics will favor the expansion of Medicaid. It may take awhile, but economic pushback will advance past political issues to move expansion forward. All 50 states will likely expand by 2019.*
>
> —**Arnie Epstein, MD**, Professor of Health Policy and Management, Harvard School of Public Health

By pushing alignment across payers, expanding Medicaid eligibility to a broader population will accelerate integrated and seamless systems of care and leverage opportunities to link payment to higher quality care. The lessons of the past 20 years provide critical guideposts as Medicaid prepares to expand its role in states across the country and, for the first time, establish a floor for universal coverage in this country.

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