



# Medicaid Makeover

## By Tommy G. Thompson

»» FOUR CHALLENGES AND POTENTIAL SOLUTIONS ON THE ROAD TO REFORM.

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## Foreward

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**M**edicaid is the largest health program in the country and is under severe pressure on multiple fronts, placing the millions of people who rely on the program at risk. Both the states and the federal government continue to struggle to fund the growing program. President Bush's budget for fiscal year 2007 includes significant cuts in Medicaid spending.<sup>1</sup> In 2003, Medicaid spending grew at a faster rate than any other category of state budget expenditures.<sup>2</sup> Medicaid enrollment jumped by one-third from 2000 through 2004.<sup>3</sup>

As some states are beginning to recognize, instead of fine-tuning our current one-size-fits-all Medicaid system, we must develop a fundamentally different system that more effectively and efficiently serves individuals. Without prompt, creative, and comprehensive action, this complex and unwieldy program, which serves as a life-line to a vastly diverse group of

disadvantaged individuals, will continue to deteriorate. Medicaid stakeholders – patients, payers, providers, and governments – must all be engaged and be part of the solution.

This white paper takes a broad look at the Medicaid program, examining four fundamental areas where improvement is needed and considering steps that could be taken to move forward on the road to reform. First, the Medicaid program does not adequately meet the health care needs of the diverse group of low-income individuals it serves: pregnant women, children, the disabled, and the elderly. Second, the Medicaid program does not efficiently encourage individuals to play an active role in their own health care. Third, Medicaid payment structures and technologies are outdated. And fourth, Medicaid is not doing its share to address the problem of the uninsured. Through a careful examination of these challenges and potential strategies and reforms for overcoming them, we can make substantial progress along the road to reform.

# Executive Summary

The time is ripe for dramatic and comprehensive Medicaid reform to improve the program's ability to meet the diverse needs of the individuals who comprise the Medicaid population, to empower individuals receiving benefits through the program, to improve core program structures, and to reach out to the uninsured. Every day new discoveries in drugs, devices, and medical procedures provide Americans with better, more personalized medical care. As significant as these medical advances may be, many Americans do not have access to lifesaving treatments and technologies because they cannot afford them. To help those who need it most, we must systematically examine the fundamental challenges faced by the Medicaid program and take concrete steps on the road to solutions.

This paper focuses on addressing four core challenges the Medicaid program faces:

- » **Meeting Diverse Needs.** How can the Medicaid program more adequately meet the health care needs of the diverse group of low-income Americans it serves: pregnant women, children, the disabled, and the elderly?
- » **Empowering Individuals.** How can the Medicaid program more efficiently encourage individuals to play an active role in their health care?
- » **Updating Structures.** What steps can be taken to update Medicaid payment structures and technologies?
- » **Addressing the Problem of the Uninsured.** What can Medicaid do to help address the problem of the uninsured?

Medicaid does not adequately meet the health care needs of the individuals who comprise the incredibly diverse population served by the program. Members of the four groups that dominate the Medicaid population – pregnant women, children, the disabled, and the elderly – generally have starkly different needs. To overcome this challenge, state and federal governments must be allowed to focus on the populations they know best. We must realign responsibility for the Medicaid program so the federal government assumes a greater role in planning for, delivering, and paying for services for the elderly – especially long-term care services – and states take on greater responsibility for caring for those under 65. Further, we must ensure that the

Medicaid program is nimble enough to allow states to address the needs of different populations differently. Taking advantage of this agility, states should create options for families and target chronic and serious needs. States should offer Medicaid families more options for meeting their health care needs, including helping families obtain commercial insurance by providing subsidies to cover the cost of participating in employer-based programs. States should also provide more coordinated, comprehensive, and targeted care for individuals with chronic needs and other serious illnesses, through care management programs and other creative options.

Medicaid does not efficiently encourage individuals to play an active role in their health care. The first, and most critical, step toward addressing this challenge is to empower individuals to take more control of their health care. To achieve this, we must methodically identify and examine barriers to empowerment and engagement in the health care process, improve the infrastructure of the Medicaid program to ensure that each individual has a health care home and receives care in a less fragmented manner, and recognize the value of (and reimburse appropriately) health literacy and other programs that promote prevention and wellness.

Medicaid payment structures and technologies are outdated. States must be encouraged to recognize and reward high quality care and improved outcomes. Steps must be taken to facilitate the implementation of new technologies, such as health information technology (HIT) and electronic medical records (EMR), to achieve efficiency and improve quality across the Medicaid care continuum.

Medicaid is not doing its share to address the problem of the uninsured. States must be encouraged to expand Medicaid coverage to lessen the strain on our health care safety net. State and local efforts to develop creative options for covering the uninsured, through public-private partnerships and otherwise, must be supported.

If we can enable the Medicaid program to meet diverse needs more adequately, empower individuals to play a more active role in their care, update core structures, and play a greater role in addressing the problem of the uninsured, we will have taken great strides along the road to reform.

# Four Challenges and Potential Solutions on the Road to Reform

The Medicaid program is in crisis on many levels, necessitating creative and thoughtful reform. Medicaid does not adequately meet the health care needs of the individuals who comprise the incredibly diverse population<sup>4</sup> it serves. Medicaid does not efficiently encourage individuals to play an active role in their health care. Medicaid payment structures and technologies are outdated. Medicaid is not doing its share to address the problem of the uninsured. These challenges can – and must – be addressed both systematically and imaginatively.

## MEETING DIVERSE NEEDS

The Medicaid population is comprised of low-income individuals with widely divergent health care needs. Reform is necessary to ensure that the Medicaid program best meets the needs of the individuals it serves. As a radical – yet essential – first step, program responsibility should be realigned to allow states and the federal government to focus on the populations they know best. Specifically, the federal government should assume a greater role in planning for and delivering services for the elderly – especially long-term care services – and states should take on greater responsibility for caring for those under 65. As a second step, states should be encouraged to address the needs of different populations differently. Several states, including Kentucky and Idaho, are beginning to experiment with this approach by providing benefit packages tailored to the needs of specific populations.<sup>5</sup> States should create health care options tailored for different subsets of the Medicaid population, such as families or individuals with chronic and serious needs. For example, states could offer Medicaid families more options for meeting their health care needs (including helping them obtain commercial insurance by providing subsidies to cover the cost of participating in employer-based programs), while providing more coordinated, comprehensive, and targeted care for individuals with chronic needs and other serious illnesses (through care management programs and other creative options).

As an initial step, while maintaining current levels of federal financial support, responsibility for the Medicaid program should be realigned to allow the state and federal governments to focus on the populations they are

best-equipped to serve. The realignment will need to be accomplished in such a way so as not to have a material impact on the distribution of financial responsibility for the Medicaid program between the federal government and the states. The extent to which individual states are impacted by the realignment will also need to be addressed.

The general concept would be to shift increased fiscal and policy responsibility for meeting the long-term care needs of the elderly to the federal government.<sup>6</sup> Primary fiscal and policy responsibility for the acute care needs of all Medicaid beneficiaries, as well as long-term care services for the non-elderly (including, for example, mental health services), would remain with the states. The realignment could be based on health care service, population, or a combination of the two. The precise allocation of responsibility between the states and the federal government would ultimately rest somewhere along a spectrum of options. One end of this spectrum would be marked by shifting full responsibility for all services furnished to elderly dual-eligible individuals to the federal government. The other end of this spectrum would be marked by shifting full responsibility for only specified long-term care services (e.g., nursing home services) to the federal government.

The Medicaid program was neither designed nor intended to become the largest primary long-term care program in the nation. Yet, in 2003, Medicaid payments accounted for 46 percent of all nursing home revenues nationwide, and individuals with Medicaid coverage accounted for more than two-thirds of all individuals residing in nursing homes.<sup>7</sup> In 2002, Medicaid payments for individuals dually eligible for Medicare and Medicaid comprised a full 42 percent of all Medicaid program spending, and 65 percent of spending for these individuals was attributed to long-term care.<sup>8</sup> Indeed, many Medicaid thought leaders have considered whether shifting more responsibility for providing health care services to the dually eligible population should play a significant role in comprehensive Medicaid reform.<sup>9</sup>

Since the federal government presently spends significantly more Medicaid dollars on acute care than on long-term care, to remain “whole,” the states will still need to receive

federal Medicaid funds following the realignment. The funding mechanism selected will need to account for the fact that state spending on long-term care services versus acute care services varies widely.<sup>10</sup> Without such adjustment, states presently devoting a significant portion of their budgets to long-term care services rather than acute care services would be “winners,” as the federal government would take on the lion’s share of their Medicaid responsibility. States focusing their resources primarily on providing acute care services would be “losers,” as shifting responsibility for long-term care services for the elderly would not have as significant an impact on their bottom line.

One option to explore for holding states harmless from the potential financial impact of the realignment is to utilize an updated Federal Medical Assistance Percentage (FMAP) formula.<sup>11</sup> A matching system seems particularly well-suited to addressing this problem because it maintains the open-ended, entitlement-based nature of federal Medicaid funding while directing more money to those states with higher post-realignment Medicaid expenditures. Other options, such as block grants, may not be as effective because of potential difficulties in accurately predicting state funding needs following the realignment of program responsibility for the purposes of setting spending caps.

The new matching system could address flaws in the current FMAP formula itself, as well as in its application. The present FMAP is based on average state personal income, which does not account for state fiscal capacity or the number of low-income people residing in a state, and is a measure that can lag when hard economic times strike.<sup>12</sup> The new FMAP formula should reflect state fiscal capacity, the number of low-income people living in the state, and also historical utilization of acute care services by state Medicaid recipients and of long-term care services by non-elderly Medicaid populations. FMAP reform should be conducted with an eye toward eliminating state financing games designed to maximize federal matching dollars drawn down.<sup>13</sup> Such gaming undermines the integrity of the program, and can skew statistics (e.g., regarding utilization) in a way that can complicate effective long-range planning.

Through this realignment, we could improve policy making and long-term planning, and provide increased flexibility to

the states. Too much Medicaid policymaking is reactionary and driven by perverse incentives. All stakeholders could benefit if we could transition to a more forward-looking policy approach that is driven by individualized needs. These reforms could enable the states and the federal government to focus on the populations they know best, and to have more flexibility to comprehensively consider and address the needs of those populations. The realignment could also present great opportunities for improving the coordination of care, which could dramatically improve health care outcomes.

Following the realignment, states will be able to focus their energies on ensuring that the needs of the populations for which they remain responsible are truly being met. We must ensure that the Medicaid program is nimble enough to allow states to design and implement health care delivery mechanisms that address the unique needs of their populations. Healthy populations should be mainstreamed into the general commercial insurance pool. The remaining populations, which would be dominated by chronically ill and disabled individuals, should be enrolled in specialized programs designed to target their individualized health care needs to achieve better health outcomes while reducing costs. The first step toward achieving these goals is to encourage states to experiment, so a paradigm can emerge.

To alleviate stress on the public insurance system and ensure access to quality care, insurable Medicaid recipients should be mainstreamed into commercial health insurance.<sup>14</sup> Shifting from a defined benefit to a defined contribution system for healthier populations could help rein in health care costs. States could act as purchasing agents for obtaining commercial health insurance (e.g., through competitive bidding), negotiating favorable premiums for enrollees, and providing subsidies for such premiums (also, the uninsured could be provided access to these favorable premiums, without the premium support). A number of states have already begun implementing premium assistance programs, which could serve as a guide for broader-based policy.<sup>15</sup>

Those for whom commercial insurance may not be a viable option, including individuals with chronic illnesses or disabilities, would continue to be covered directly by the

state. Rather than a defined contribution model, an intensive disease management approach could be deployed. These programs would be tailored to the specialized needs (e.g., diabetes, multiple sclerosis, or mental illness) of individuals in the state's Medicaid population. For example, for the chronically ill, disease management services could include counseling individuals regarding the importance of adherence to treatment regimens, monitoring compliance with treatment regimens, and ensuring that enrollees engaged in healthy behaviors. These efforts could be coupled with a benefit package that includes a generous formulary, designed to ensure that specialized needs can be readily met. For individuals suffering from chronic mental illnesses, efforts could focus on providing targeted case management as well as prescription drug coverage, rehabilitation services, and other specialized provider services. Benefits would be patient-driven, rather than prepackaged with the average health care consumer in mind. The key to cost savings lies with improved management and support of these high cost populations.<sup>16</sup>

Fostering and incorporating best practices from state Medicaid programs will help define the options for other states. "Model" waiver (or state plan amendment) components could be developed, perhaps as part of a "policy toolbox,"<sup>17</sup> that draw upon innovative reforms already being implemented by various states. The toolbox could include components designed to test innovative ideas (e.g., cash and counseling programs) or to target different populations (e.g., home and community-based services).

In sum, to maximize the ability of the Medicaid program to meet individualized needs, states and the federal government should be allowed to focus on the populations they know best. Responsibility for the Medicaid program should be realigned so the federal government assumes a greater role in planning for and delivering services for the elderly, and the states take on increased responsibility for caring for those under age 65. Following the realignment, states should transition healthy populations into more cost-effective commercial insurance. For those remaining in public programs, states should develop health care delivery models designed to meet individualized needs and maximize health care outcomes. States, as "laboratories of democracy," should be encouraged to

engage in bold, thoughtful reform efforts and experiment with reasoned approaches for achieving these goals.

## EMPOWERING INDIVIDUALS

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The Medicaid program does not efficiently encourage individuals to play an active role in their health care. Prompt and targeted action is needed to empower individuals to take more control of their health care. We must methodically identify and examine barriers to empowerment and engagement with the health care system, and improve the infrastructure of the Medicaid program to ensure that each individual has a health care home and receives care in a less fragmented manner. Moreover, we must recognize the value of and reimburse appropriately health literacy and other programs that promote prevention and wellness.

The first step in empowering individuals to play a more active part in their health care is to identify barriers preventing them from taking this initiative. This inquiry will need to be conducted at the state and local level. Factors such as language, literacy, bias, and logistical challenges (e.g., transportation or child care needs) will need to be evaluated systematically before an action plan can be developed.

In a similar vein, steps must be taken to ensure that each individual receiving Medicaid benefits has a health care home. Fragmented care too often results in poor health outcomes, in addition to fostering frustration with the system that may discourage future utilization of services. Individuals must know, and be comfortable with, the access points for care. And these access points must be worthy of this role, and able to ensure access to quality, coordinated care. States (like West Virginia) are beginning to recognize the importance of the medical home, and are taking innovative steps to ensure that individuals establish and maintain such a home.

Through health literacy programs, disease prevention programs, outreach and education programs, and flexible incentive programs, Medicaid recipients can be further encouraged to take more control of their health care decisions. These initiatives should receive funding priority. Everyone wins if the Medicaid population becomes

healthier. Individuals clearly reap the most rewards, but state coffers would benefit as well, since healthier individuals are generally less expensive to treat.

Increasing health literacy among the members of the Medicaid population will lead to better health care outcomes and a more efficient and effective Medicaid program. Health literacy programs target patients' ability to read, understand, and act upon health information. Individuals cannot receive quality health care services if they cannot communicate effectively with medical professionals. The lower the literacy level, the lower quality of health care often received by the patient.<sup>18</sup> Individuals must understand their own health care needs, and have adequate support and guidance to navigate their options effectively to meet those needs. Further, individuals cannot take full advantage of program options they do not fully understand, and may be at risk (financially as well as health-wise) if they make uninformed choices.<sup>19</sup> Health literacy skills can be a strong predictor of health status.

Lower health literacy levels are also linked to increased state and federal costs. Miscommunication or inadequate sharing of information can lead to ineffective, counterproductive, and even harmful health care. For example, a patient may not receive the most appropriate care if he or she lacks the vocabulary to communicate an allergy to a particular medication. Similarly, cultural differences that may exist regarding the administration of medication (e.g., crushing versus swallowing pills) must be resolved through clear communications between physicians and patients. Lower literacy can lead to more medical errors and diminished patient compliance with health care regimens, which can result in injury, death, and higher costs to the health care system.

The federal government should reward states that work to improve the health literacy of their patient populations, and states should reward providers for such efforts. States and providers should be encouraged to develop innovative approaches to improving provider-patient communications. For example, individuals may find it easier to communicate basic information to health care providers if all Medicaid providers used a common patient intake form. If the Internal Revenue Service can adopt a single, simple form – the 1040 – Medicaid

providers should be able to do the same. The resulting standardization of information could also facilitate a transition to an EMR environment or other HIT utilization.

Disease prevention programs are another powerful tool for encouraging individuals to play an active role in their health care. The federal government should ensure the states present Medicaid recipients with strong incentives designed to foster participation in disease prevention programs, like smoking cessation programs and weight loss programs. Policymakers are beginning to grasp the importance of these programs in maximizing health outcomes and achieving cost savings. For example, in March 2005, CMS concluded that there was adequate evidence to support Medicare coverage for smoking and tobacco use cessation counseling for Medicare beneficiaries who suffer from smoking-related illnesses or who are being treated with medications that are affected by tobacco use.<sup>20</sup> Further, smoking cessation treatments prescribed by a physician are covered by Medicare Part D.<sup>21</sup> The Medicaid program should take an even more comprehensive and innovative approach to incorporating these outcome-improving and cost-saving tools.

The federal government should require states to make disease management programs available to Medicaid recipients, and should offer states financial incentives, such as enhanced matching, for services furnished in connection with such programs.<sup>22</sup> A federal mandate and state financial incentives may be particularly important given that, depending upon the specific program undertaken, states may not see correlating reductions in health care costs.<sup>23</sup> However, beyond the innate value of fostering a healthier population, it is important not to lose sight of the fact that young Medicaid recipients are the Medicare beneficiaries of the future. To the extent that the federal government can encourage participation in smoking cessation programs and similar preventive programs, the Medicare program will reap the benefits in terms of reduced costs down the road.

Several states have started innovative programs aimed at achieving cost savings through encouraging preventive care. For example, in West Virginia, certain individuals will only be eligible for an enhanced benefits package if they sign a

Medicaid Member Agreement providing, among other terms, that the individual agrees to adhere to health improvement programs as directed by his or her health care provider.<sup>24</sup> Members failing to abide by this obligation will be removed from the enhanced benefit plan and will be enrolled in a more basic benefit plan.<sup>25</sup> Once disqualified from participating in the enhanced benefit plan, individuals will have to wait twelve months from the time of disqualification to re-enroll and sign a new Medicaid Member Agreement.<sup>26</sup> In Florida, the state will be creating accounts for qualified enrollees, who can earn contributions to those accounts for good health practices, such as participating in a smoking cessation program.<sup>27</sup> Account funds can be used to purchase non-covered health care items.<sup>28</sup> In Tennessee, overweight Medicaid recipients can enroll in Weight Watchers programs at a discounted rate.<sup>29</sup>

Beyond health literacy, and in addition to disease prevention programs, patient outreach and education programs play an important role in empowering individuals to play an active role in their health care. Programs designed to educate individuals about their own health care and status should be prioritized. Individuals must have a good understanding of their past, present, and future health in order to make prudent health care decisions. For example, states should work to encourage providers to implement beneficial HIT. Electronic health records, for instance, can provide patients and providers with a patient's comprehensive medical history, which could affect treatment options and decisions.<sup>30</sup> Providers should work with patients to educate them on the potential benefits and risks of each available treatment option, taking into consideration each patient's medical history. In addition, providers should not permit chronically ill patients to walk away from their care believing they have no options. Rather, these patients should be educated on how their chronic condition can be managed.<sup>31</sup> States should be working toward educating patients on a variety of issues including understanding risk factors for the prevention of diseases, providing knowledge about specific diseases to sufferers, their families, and caretakers, and promoting healthier lifestyles.

Finally, healthy populations should be given an opportunity to exert more control over their health care expenditures, reflecting the growing trend toward consumer-directed

health care in the private sector.<sup>32</sup> In the public sector, these initiatives include both large-scale efforts (like tax credits designed to enable low-income individuals to purchase private health insurance similar to the Federal Employees Health Benefits Plan where enrollees receive a defined contribution from the government that can be used to select from among many insurance options) and small-scale efforts (like enhanced benefits accounts into which the state deposits funds to reward certain healthy behaviors, which can be used for health care-related expenses). These mechanisms, which are becoming available to Medicaid recipients in some states already, can empower beneficiaries to make better health care choices.

These options are not a panacea, and are not necessarily well-suited for all Medicaid populations, but, if wielded with care, can be a powerful tool in empowering individuals and achieving cost savings. Importantly, these options may be beneficial to non-disabled, non-aged adults, but should not be considered for mentally ill or aged populations. Even when deployed for appropriate populations, increased decision-making tools can present risks where individuals do not make informed decisions. Consumer-directed tools should be supported through extensive outreach and counseling.

Overall, moving from a payer-focused to a patient-focused health care delivery model will improve the ability of Medicaid recipients to manage their own care. Barriers to quality care and participation in the health care process must be systematically identified, examined, and torn down. Steps must be taken to ensure each Medicaid recipient has a true Medicaid health care home. This can empower individuals to participate in health decisions and encourage them to continue to access the system in the regular course of meeting their health care needs – rather than waiting until they are presented with a health care crisis necessitating a visit to the emergency room. States and the federal government should think creatively about ways to increase health literacy, encourage individuals to engage in healthy behaviors (such as participating in weight loss or smoking cessation programs), and engage in substantive outreach and education efforts. Consumer-directed care could also play a measured role in the reform effort. Individuals who are more engaged in the health

care process should enjoy improved outcomes, and, as a result, should generally be less expensive to treat.

## UPDATING CORE STRUCTURES

Medicaid payment structures and technologies are outdated, resulting in increased costs and diminished quality. Payment systems should be updated to reward quality of care, rather than simply quantity of services, and states should be encouraged to undertake eHealth initiatives to improve quality, safety, and cost-effectiveness across the Medicaid care continuum.

Medicaid payment structures should be updated to include a mechanism for rewarding providers and practitioners for enhancing the quality of care. Throughout the past 40 years, the reimbursement system has centered on rewarding the quantity of services provided, with a small shift in recent years toward rewarding the treatment of more patients at less cost. The element that has been missing is a measurable focus on the quality of outcomes and on rewarding states for their ability to improve outcomes, which lowers the current and future cost of care.

Improving the quality of care depends largely upon two key factors. The first factor is the ability to track quality and to define what it means to provide quality care. Currently, many provider-developed care plans do not adhere to best practices. The Centers for Medicare and Medicaid Services, through the Medicare program, has begun to take the lead in tracking quality measures on a test basis, and early results have shown a 6.6 percent increase in quality across these measures by providing a one to two percent financial incentive for those performing in the top 20 percent of any of the measured categories.<sup>33</sup> The second factor for improving quality is the establishment of a reward system that encourages thin-margin providers to invest in designing around quality. The potential for adding one or two percent to such a provider's margin can be enough of an impetus to invest in designing for quality. It is important to ensure that the reward is financially viable and offsets the costs of change, rather than a mere system of penalties for not reporting or achieving quality indicators. Both the tracking of best practices and the tracking of errors allow for a more value-based reimbursement. States should be encouraged to design programs that revolve around these practices.

The Medicaid program is ready for a technology overhaul (or, in some cases, for the introduction of technology). eHealth resources improve the ability to collect, store, and communicate information. They also provide a standardized collection of information to support public health campaigns. Public health information can be particularly valuable in preventing the spread of disease, such as influenza. With a wealth of new data in an organized format, officials at the state and federal levels can use data mining techniques to isolate areas for improvement. Rhode Island, for example, recently mined its Medicaid database to find patterns among those taking drugs with a high risk of suffering falls.<sup>34</sup>

Electronic medical records connect providers to one another for the diagnosis and tracking of disease. When access to some EMR information is made available to the consumer, it can be combined with targeted lifestyle information to improve the management of chronic illness or to suggest and reward behavioral changes, such as controlling cholesterol. A system that connects consumers to their care network can also communicate the cost and quality of care. Educating the consumer on the cost and quality of care helps the successful implementation of individual accounts in consumer-driven models. States implementing a cross-system EMR will experience the secondary benefit of a reduction in costly repeated testing to reestablish the health record of a patient. Technology allows stakeholders to connect to information that has not been available before, and Medicaid can benefit by putting that interconnectivity to creative use.

Technology also allows increased access to care by removing the necessity to put the specialist in the same room as the patient, which can also significantly reduce costs. Telemedicine allows patients in rural hospitals to work with their local physician to take images such as x-rays and ultrasound and have experts analyze the images from their desks halfway around the country or around the globe. Telemonitoring increases compliance by bringing the nurse into the home of a chronically ill patient through tracking of self-administered medication and diagnostics. For instance, a patient with diabetes would scan his daily blood tests into a machine that connects to his physician's office over a secure internet line.

The physician could use the data to track the success of a drug regimen and be able to improve the therapy.

One of the first steps in creating an eHealth environment is connecting the physicians to the system. Florida has successfully used e-prescribing to check medication side effects, patient prescription histories, and track costs. Florida gave PDAs to the physicians with the highest volume of Medicaid patients. The accompanying system allowed for real-time data on current medication history. Physicians acting with this new information dropped severe drug reactions from seven to four percent.<sup>35</sup> Officials expect the program to save four million dollars in 2006.<sup>36</sup> While states have created some innovative programs, the continued success of eHealth initiatives requires a commitment from Medicaid to pull the pieces together and overcome any access or compatibility issues. eHealth interconnectivity need not happen all at once, but Medicaid needs to use its size and reach to have a strong hand in defining standards. Medicaid needs a system of rewarding those states that plug themselves and their recipients into a single network. The technology needed to increase eHealth already exists, but the large upfront cost is a barrier that Medicaid could help lower and create the groundwork for long-term savings.

In achieving the Medicaid Makeover, core program structures must be revisited and overhauled. Payment structures must be updated to more directly reward quality, and technologies must be deployed across the program to improve efficiency, safety, and quality.

## HELPING ADDRESS THE PROBLEM OF THE UNINSURED

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Medicaid is not doing its share to address the problem of the uninsured. In 2004, the number of uninsured Americans rose to 45.8 million people – 15.7 percent of the population of the United States.<sup>37</sup> Multiple complex forces, such as state and national economic trends, the labor market, the cost of health care, and the availability of reasonably priced insurance, converge and contribute to the problem of the uninsured.<sup>38</sup> States must be encouraged to expand Medicaid coverage to lessen the strain on our health care safety net. States should develop creative options for covering the uninsured, through public-private partnerships and otherwise. The Medicaid

program should be supportive of local efforts to provide coverage for more of the uninsured. The Medicaid program, and states in general, must do more to be part of the solution.

States should expand coverage to reach more low-income individuals. Once responsibility for the Medicaid program has been realigned to shift increased responsibility to the federal government for providing services for the elderly, state policymakers will be better able to focus their energies on problems like reaching out to the uninsured. Funds freed by steps taken to improve the general health and well-being of the Medicaid population, and to update Medicaid structures, should increase resources available for targeting the problem of the uninsured. As with the traditional Medicaid population, states could provide standard insurance products for healthier individuals within the expansion population, and targeted care for those with chronic needs and other serious illnesses.

Just as a “one-size-fits-all” approach to Medicaid benefit design fails to meet the needs of individuals, a “one-size-fits-all” approach to initiatives targeting the uninsured fails to address adequately the distinct needs of different regional markets. Indeed, different regions of the country face unique challenges with respect to the uninsured, warranting tailored approaches. For example, between 2000 and 2004, more than half of the growth in the total number of uninsured Americans occurred in the South.<sup>39</sup> In Texas, for instance, on average, 25.1 percent of the population lacked health insurance between 2002 and 2004 – compared to a national average uninsurance rate of only 15.5 percent,<sup>40</sup> and several regions within the state have proven to be uninsurance “hot spots.” For example, a 2004 study found that 31.4 percent of the Houston/Harris County population (or 1.1 million people) were uninsured – and this number does not account for the thousands of evacuees from Hurricane Katrina now living in the Houston/Harris County region.<sup>41</sup>

The Medicaid program, and states generally, should support creative options designed to provide solutions tailored to critical yet localized needs. Massachusetts, for example, has made a serious commitment to addressing the problem of the uninsured. Beginning July 1, 2007,

every resident in Massachusetts will be required to have health insurance.<sup>42</sup> Key components of the plan include redirecting state funds now used to reimburse providers for uncompensated care to help low-income individuals purchase insurance, state-sponsored premium support for low-income individuals, requiring employers that do not offer insurance coverage to employees to pay a fee, and allowing insurers to develop plans that are not held to all of the state coverage requirements mandated by the state for certain populations.<sup>43</sup>

The Medicaid program, and the states in general, must play a more significant role in addressing the problem of the uninsured. Uninsured individuals are more likely to go without necessary care and suffer poorer health outcomes, creating a strain for the health care safety net. Creative solutions, targeted to specific needs, must be developed and supported.

## Conclusion

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**T**he Medicaid program is in dire need of reform. Medicaid does not adequately meet the health care needs of the diverse group of low-income Americans it serves. Medicaid does not efficiently encourage individuals to play an active role in their health care. Medicaid payment structures and technologies are outdated. Medicaid is not doing its share to address the problem of the uninsured. Each of these problems can be addressed, systematically and effectively. Some warrant an approach that may seem radical, while others seem readily addressed through less dramatic measures. We must move steadily ahead on the road to reform. By identifying challenges one at a time, and developing strategies for addressing them, we take incremental yet critical steps toward completing the Medicaid Makeover.

1. *The President's Fiscal Year 2007 Budget – Health* (2006), <http://www.whitehouse.gov/omb/pdf/Health-07.pdf>.
2. Nat'l Ass'n of State Budget Officers, *2003 State Expenditure Report 2* (2003), <http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf>.
3. Vernon K. Smith & Greg Moody, Health Mgmt. Assocs., *Medicaid in 2005: Principles & Proposals for Reform 7* (prepared for the Nat'l Governors Ass'n) (Feb. 2005).
4. The Medicaid population, which includes both mandatory and optional coverage groups, is extraordinarily diverse. Mandatory population groups include individuals who meet defined criteria in certain eligibility categories (i.e., the “categorically needy”), such as: low-income families with children; elderly, blind, and disabled individuals receiving Supplemental Security Income (SSI) (and satisfying other requirements that may vary by state); infants born to Medicaid-eligible women; children under the age of six and pregnant women whose family income is at or below 133 percent of the Federal Poverty Level (FPL); and certain low-income Medicare beneficiaries and specified protected groups. See Kaiser Comm'n on Medicaid & the Uninsured, *Pub'l'n No. 7254, Medicaid's Optional Populations: Coverage & Benefits 1-2* (2005). Optional populations to whom states may also provide coverage include, for example, the medically needy and pregnant women, subject to certain income thresholds. *Id.* at 1. Every state has expanded coverage to include optional populations; in fact, 29 percent of all Medicaid beneficiaries qualify for coverage on the basis of belonging to an optional eligibility group. *Id.* at 1-2. Many states consider coverage of “optional” population groups to be essential. *Id.* at 1.
5. See Cabinet for Health & Fam. Servs., Dep't for Medicaid Servs., KY Health Choices: Kentucky's Updated Medicaid Transformation Initiative 11-12 (2006); Leslie M. Clement, Dep'y Adm'r. Idaho Dep't of Health & Welfare, *Medicaid Info. Release MA06-18* (July 2, 2006), <http://www.healthandwelfare.idaho.gov/>. States are beginning to combine new authority available under the Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, 120 Stat. 31 (2006), together with existing waiver authority to engage in broad-based reform to tailor their Medicaid programs more closely to individualized needs. See, e.g., Cindy Mann & Samantha Artiga, Kaiser Comm'n on Medicaid & the Uninsured, *New Developments in Medicaid Coverage: Who Bears Financial Risk & Responsibility?* 11-12 (2006) (discussing “tiered” benefits developed by states under DRA authority).
6. The specifics of the newly expanded Medicare long-term care benefit are beyond the scope of this paper. Beyond determining how to structure the basic benefit and the precise scope of services that would be shifted to the federal government, additional consideration will need to be given to questions such as the extent to which means testing would play a role in the new Medicare benefit, how the expanded Medicare benefit would be financed, how to set provider rates following the realignment, and what role commercial long-term care insurance should play with respect to the benefit.
7. Smith & Moody, *supra* note 3, at 5 (citing Cynthia Smith et al., *Health Spending Slows in 2003*, Health Affairs (Jan.-Feb. 2005) (based on Nat'l Health Care Expenditure Data, Ctrs. for Medicare & Medicaid Servs., Office of the Actuary)).
8. Kaiser Comm'n on Medicaid & the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* (2004). Significantly, during this same time period, dual eligibles only accounted for 16 percent of all Medicaid enrollees. *Id.*
9. See, e.g., Smith & Moody, *supra* note 3, at 17 (recommending amending “federal Medicare law so the federal government assumes specific responsibility for low-income Medicare-Medicaid dual eligibles, including full payment of premiums, coinsurance, and deductibles”); Cindy Mann & Tim Westmoreland, *Devising Solutions: Attending to Medicaid*, 32 J.L. Med. & Ethics 416, 421 (Fall 2004) (“The federal government ... should assume more responsibility for the impact of the aging population and the burgeoning cost of serving people who are receiving both Medicare and Medicaid.”); Nat'l Governors Ass'n, *Medicaid Reform: A Preliminary Report from the Nat'l Governors Ass'n 2* (2005) (“What is clear is that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for the dual eligibles.”).
10. See, e.g., Ellen O'Brien, Georgetown Univ. Health Pol'y Inst., *Long-Term Care: Understanding Medicaid's Role for the Elderly & Disabled* Table 1 at 22, 23 (Nov. 2005) (prepared for the Kaiser Comm'n on Medicaid & the Uninsured) (analyzing table and noting that “[s]pending on long-term care varies across states ... [l]ong-term care represents more than 50 percent of spending in North Dakota (58 percent), and Connecticut (51 percent) and less than [a] quarter of Medicaid spending in Tennessee (21 percent), Nevada, South Carolina, and South Dakota (23 percent).”).
11. The Medicaid program is jointly funded by the states and the federal government. Since Medicaid is an entitlement program, the federal government matches state spending on an open-ended basis, applying the FMAP formula each year to determine the matching rate for each state. The FMAP is designed to provide greater subsidies to states with lower average personal incomes. In fiscal year 2004, for example, FMAPs varied from 50 percent in 12 states to 77.08 percent in Mississippi, and averaged 60.2 percent overall. Ctrs. for Medicare & Medicaid Servs., *Gen. Medicaid Info.* (2005), [http://www.cms.gov/MedicaidGenInfo/03\\_TechnicalSummary.asp](http://www.cms.gov/MedicaidGenInfo/03_TechnicalSummary.asp).
12. See, e.g., Smith & Moody, *supra* note 3, at 13 (“The formula for the FMAP is based on average state personal income, which is a poor measure of state fiscal capacity. Even to the extent that the FMAP reflects changes from year to year, it does so with a significant lag. The result is that some states experience a drop in the federal matching rate at a time when state revenues are declining due to an economic downturn, further exacerbating state difficulties.”); Lynn Etheredge & Judith Moore, *A New Medicaid Program*, Health Affairs Health Ins. Forum W3-431 (2003) (“... the matching formula excludes the critical element of a state's population in need—numbers of low-income people—and lacks an accurate measure of a state's fiscal capacity”) (citing U.S. General Accounting Office, Pub. No. GAO-03-620, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened* (July 2003)). It would be particularly important for the new FMAP to reflect state fiscal capacity, as states presently devoting a significantly larger percentage of their Medicaid budget to long-term care services for the elderly would have greater fiscal capacity following the realignment.
13. Cf. Nina Owcharenko, The Heritage Found., *Backgrounder No. 1863, A Roadmap for Medicaid Reform 7* (2005).
14. See, e.g., Nina Owcharenko, The Heritage Found., *Executive Mem. No. 846, How States Can Expand Private Coverage with HIFA Waivers* (2002) (“With declining access to quality care becoming a growing problem under Medicaid, states should give Medicaid and SCHIP beneficiaries the opportunity to purchase private health insurance by providing assistance through a premium subsidy. States should utilize the HIFA waiver to allow enrollees to change from state-sponsored coverage to a private coverage option of their own choosing. Mainstreaming certain Medicaid and SCHIP populations into private coverage will also help to ease the obligations on state-provided coverage and improve the quality of care for the truly indigent who must receive coverage through the state.”).

15. See, e.g., Joan Alker, Kaiser Comm'n on Medicaid & the Uninsured, Issue Paper, *Premium Assistance Programs: How Are They Financed & Do States Save Money?* (2005) (examining premium assistance programs implemented under Section 1115 waivers in Illinois, New Jersey, Oregon, Rhode Island, and Utah). Notably, some of the programs implemented through Section 1115 waivers prior to the passage of the DRA could possibly now be accomplished under DRA authority.
16. Cf. The Urban Inst., *Five Questions for John Holahan* (2005), <http://www.urbaninstitute.org/toolkit/fivequestions/JHolahan.cfm> ("... I think the real savings in Medicaid are going to come only with managing high-cost populations better. Right now, 4 percent of the Medicaid population accounts for 53 percent of Medicaid spending. Another 3 percent account for 12 percent of spending. So you have 7 percent of the Medicaid population, about three million people, who get two thirds of all Medicaid dollars. There is a lot of potential savings through better management of these cases.").
17. *Enhancing Federalism to Address Medicaid & the Uninsured*: Hearing Before S. Comm. on Finance, 109th Cong. (2005) 4 (statement of Stuart M. Butler, Ph.D., Vice President for Domestic & Economic Policy Studies, The Heritage Found.) (recommending that Congress enact a "policy toolbox" of diverse federal Medicaid reforms or programs that would be available to states, but not required).
18. See The Cal. Health Literacy Initiative, *Low Literacy, High Risk: The Hidden Challenge Facing Health Care in California* 1 (2003).
19. See Smith & Moody, *supra* note 3, at 16.
20. See Ctrs. for Medicare & Medicaid Servs., *Smoking Cessation – Overview* (2005), <http://www.cms.hhs.gov/SmokingCessation/>.
21. *Id.*
22. It will be critical to monitor outcomes to prevent abuse. History has shown that matching-based initiatives can present perverse incentives that lead actors to engage in otherwise irrational behaviors. With vigilance, however, problems such as an undue proliferation of programs, enrollment of individuals who are not good candidates for participation, and low program quality can generally be avoided. For example, toward this end, the federal government could establish standards that disease prevention programs would need to meet to be eligible for an enhanced matching rate. These standards could not only outline the key substantive elements for such programs, based on best practices, but could also include requirements for education and outreach initiatives designed to ensure that Medicaid recipients are aware of the program and for evaluating outcomes.
23. One cost-benefit analysis focusing on smoking cessation programs, which was conducted at the request of the Washington State Legislature in 2002, found that "[t]he adoption of a Medicaid smoking cessation treatment program would cost more than it saves, regardless of which Medicaid group is considered, when viewed from the standpoint of short-term impacts." Steve Lerch, Ph.D., Wash. State. Inst. for Pub. Pol'y, *Smoking Cessation & Medicaid Expenditures* 25 (June 2002). While acknowledging that "[t]he reduction in preventable deaths, increase in years of life, and potential reduction in lifetime health care expenditures attributable to smoking cessation are all desirable outcomes[,]," the analysis noted that "when smoking cessation treatments are provided to Medicaid enrollees, all of the costs—but only a fraction of these savings—accrue to the Medicaid program." *Id.* Program costs are incurred now, but potential financial savings are realized over time. *Id.* at 1. People tend to move on and off the Medicaid rolls, so they may not even be enrolled by the time cost savings from their efforts would be realized. *Id.*
24. Ctrs. for Medicaid & State Operations, *West Virginia's Medicaid State Plan Amendment* (2006), [http://www.wvdhhr.org/bms/oAdministration/bms\\_admin\\_WV\\_SPA06-02\\_20060503.pdf](http://www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf).
25. *Id.*
26. *Id.*
27. Fla. Agency for Health Care Admin., *Florida Medicaid Reform: Application for 1115 Research & Demonstration Waiver* 100 (2005).
28. *Id.* at 5.
29. See Media Release, State of Tenn., Bureau of TennCare, *TennCare Tackling Obesity through Weight Loss Program with Weight Watchers* (Nov. 15, 2005), [http://www.tennessee.gov/tenncare/news/2005\\_Releases/weight\\_watchers\\_partnership111505.pdf](http://www.tennessee.gov/tenncare/news/2005_Releases/weight_watchers_partnership111505.pdf).
30. See, e.g., Am. Health Info. Cmty., Office of the Nat'l Coord. for Health Info. Tech., Dep't of Health & Human Servs., *Potential Breakthroughs* (2005), <http://www.hhs.gov/healthit/breakthroughs.pdf>.
31. See, e.g., Bruce Shutan, *ABCs of Health Care: Educational Campaigns Are Afoot to Improve Patient Understanding & Save on Unnecessary Care & Costs, Risk & Insurance* 12 (2001).
32. See Owcharenko, *supra* note 13, at 5 ("Policymakers should focus on approaches that are patient-centered instead of system-centered. The current Medicaid structure is based on a system that reimburses providers for the services they supply to beneficiaries. A patient-centered approach would direct Medicaid funds to the patient and reflect the individual needs of that patient.").
33. See Ctrs. for Medicare & Medicaid Servs., Fact Sheet, *Rewarding Superior Quality Care: The Premier Hospital Quality Incentive Demonstration* (2006), [http://www.cms.hhs.gov/HospitalQualityInits/35\\_HospitalPremier.asp](http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp); Premier, Inc., *Centers for Medicare & Medicaid Services/Premier Hospital Quality Incentive Demonstration Project: Findings from Year One 4* (2006), <http://www.premierinc.com/all/quality/hqi/resources/HQIwhitepaper-4-13-06.pdf>.
34. PEW Ctr. on the States, *Special Report on Medicaid: Bridging the Gap between Care & Cost* A16-A17 (2006).
35. *Id.* at A16.
36. *More Florida Docs Could Get Handheld Prescribing Devices* (May 6, 2005), <http://www.ihealthbeat.org>.
37. Robert Wood Johnson Found., Academy Health (State Coverage Initiatives), *State of the States: Finding Their Own Way* 7 (2006) (citing the Current Population Survey released in 2005).
38. *Id.* at 11, 17.
39. *Id.* at 8.
40. U.S. Census Bureau, *Income, Poverty, & Health Insurance Coverage in the United States: 2004* 27 (Aug. 2005).
41. See Greater Houston P'ship, *Public Health Task Force Executive Summary* 3 (2004), <http://www.hcphsc.hctx.net/Documents/>.
42. Press Release, The Commw. of Mass., Exec. Dep't, *Romney Signs Landmark Health Insurance Reform Bill* (Apr. 12, 2006), <http://www.mass.gov>.
43. *Id.*; see also Kate Schuler, *Massachusetts' Health Plan*, Cong. Q. HealthBeat (June 5, 2006).

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