Testimony to the Medicaid Commission

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Chairman Sundquist, Chairman King, Governor Bush, Governor Manchin and Members of the Commission, thank you for the opportunity to testify this afternoon. My name is James Frogue and I am the State Project Director at the Center for Health Transformation (http://www.healthtransformation.net/) a three-year-old organization founded by former Speaker of the House of Representatives Newt Gingrich. In my role, I work with state officials to create and implement health policies that improve the quality of care for individuals at lower cost. We are of the view that the health policy debate of 2006 and into the future demands suggestions that accomplish these twin goals simultaneously. We fully appreciate that this can, at times, be disruptive to the status quo.

We have six specific goals in our Medicaid Transformation Project:

- Eliminate racial and socio-economic health disparities
- Make the individual patient the center of health decision-making
- Leverage Medicaid to achieve 100 percent insurance coverage
- Encourage governors to accept greater direct oversight and responsibility for their respective Medicaid programs
- Transform the administration of Medicaid to an entrepreneurial culture that seeks innovative solutions and embraces results over process
- Emphasize health before health care

The topic of Medicaid is one of the two or three most pressing issues in all 50 state capitals. It becomes increasingly obvious to state officials every year that Medicaid spending is on pace to crowd out other budget priorities such as education, highways, law enforcement, and environmental protection among others. It is also becoming ever more apparent that Medicaid is not living up to its potential in delivering optimal health outcomes. That is a direct result of both its current structure and the general unwillingness of elected officials to attempt the kind of radical reforms that Medicaid truly needs.

My goal here today is to touch on some of the promising breakthroughs occurring in Medicaid programs across the country so that they can be duplicated, enhanced and expanded. It is not to dwell on what ails the current system, although I must briefly start there.

Medicaid is a 1960s era system of government-defined benefits and prices. That model no longer exists in any other industry in our economy. Imagine trying to explain to producers and consumers of housing, food, automobiles, cellular phones, and computers (all items very critical to daily life in 2006) that quality, consumer choice, and innovation would improve if the federal or state governments stepped in to heavily regulate product offerings and prices. No one would pay any attention to you and appropriately so. Yet that archaic model dominates Medicaid.

Discussions of Medicaid reform in state capitals tend to involve only four options:

1. Cut people (euphemistically referred to as cutting "eligibility")
2. Cut reimbursement rates paid to providers
3. Cut benefits
4. Blame Congress

None of these choices will result in the kind of real, pro-patient transformations that are necessary.

The result is that standard fee-for-service Medicaid is a system characterized by provider withdrawal, reactive and episodic patient care with limited (if any) coordination, and virtually no mechanisms for truly improving the health of low income Americans over the long run. After all, Medicaid's sole goal should be improving the health outcomes of beneficiaries by any means necessary.

A more intelligent, efficient Medicaid program will be able to serve more people with better results. Enlightened state officials have a range of options to pursue that will improve the delivery of care. First is to emphasize wellness. People who do not get sick in the first place cost less. This strategy goes beyond the Medicaid program and involves stripping the junk food out of schools and requiring physical education in grades K-12. Poor diets and inactivity lead to obesity and a host of related ailments, notably Type 2 Diabetes. If policymakers wish to avoid the tidal wave of obesity-linked illness in the

decades ahead, they will strike at the root of the problem and pursue an agenda that fosters healthy habits in children.

Second, technologies are available that can deliver markedly better care at a fraction of the cost. Electronic health records and e-prescribing are already helping to eliminate medical errors, coordinate and monitor treatments, and reduce fraud. Recent studies conclude that universal adoption of electronic health records could eventually save hundreds of billions of dollars per year across our health system. For only $25, a physician can set up an account at ihealthrecord.org for an unlimited number of patients. E-prescribing could prevent more than 2 million adverse drug events annually and 190,000 needless hospitalizations. Advances in telemedicine and telemonitoring offer massive potential to improve care for people confined to their home or institutions.

Third, Medicaid must evolve from a system of defined benefits and prices into a funding stream to help finance individually owned and chosen insurance arrangements. The ideal health care system is one that supports continuity of care. This is particularly important for individuals with one or more chronic conditions. It does not make sense, indeed it can be harmful, for people to bounce among different plans, and in and out of coverage. Medicaid dollars must be available to help poor people afford employer-sponsored health insurance or to maintain their individually-owned Health Savings Account. This will also help eliminate the so-called Medicaid "cliff" problem whereby people are cut off entirely once they reach a certain income level. The "cliff" can discourage people from reintegrating into the workforce out of a legitimate fear that they will suffer loss of coverage.

Fourth, proper disease management targets resources and care where it is needed most – on the highest cost individuals. In most states, it is roughly 5 percent of the people on Medicaid who run up 50 percent of the cost. It simply makes sense to focus time and attention on this population instead of cutting many more people off the rolls. The November 2005 meeting of the National Association of State Medicaid Directors focused on successes in disease management thus far and its major potential going forward. The Disease Management Association of America is a non-profit organization that is a wealth of information about the subject area.

Fifth, the government via Medicaid and other initiatives must be a facilitator of information about health care services and providers. Unfortunately, it remains the case that our health care system is the most opaque sector of our economy. Information about prices complete with quality ratings and product comparison are commonplace in the markets for cars and computers, for example. Even in the age of the Internet, this information is not nearly as available as it must be in the health care sector. Without accurate information there cannot be educated consumers making appropriate decisions. State government can help shine more light on health care providers.

Finally, it must be clear to policymakers that changing behavior at the patient level is the ultimate key to solving Medicaid over the long term. The above five strategies are all helpful in that regard. Pay-for-compliance incentives are the best way to supercharge

appropriate behavior. Some private, non-Medicaid insurance plans are now offering incentives like $250 cash for taking an introductory physical and subsequent, similar rewards for enrolling with a health coach, and still more cash for achieving and/or maintaining a particular weight, cholesterol number, or A1C figure. It is precisely these kind of creative programs that will have a major positive impact on patient behavior and therefore on health outcomes and long term cost.

There are many administrations across the states that are pursuing combinations of these strategies and others. In my brief time here this afternoon I want to scan several of them. For more examples and more detail, I encourage the Commission and any interested parties to visit our website. Beginning early next month we will have a "Best Practices in Medicaid" section on our home page that will be searchable by state. We are in the process of inviting all 50 governors' offices to participate and send us what they believe to be their most effective initiatives in nine areas. We will be posting the responses unedited on our site with the understanding that they can be updated and altered at any time in the future as more progress is made.

At the risk of sounding too eager to please Governor Bush, the state that has made the most progress thus far in transforming Medicaid is Florida. The Florida plan involves all of the elements previously discussed here. Individuals and families on Medicaid will be allowed to select from a range of competing networks in their geographic region. An enhanced benefit package will be available to beneficiaries as an incentive to demonstrate healthy behaviors and improvements. Medicaid dollars will also be available to individuals to help subsidize the cost of enrolling in an employer's plan.

Florida was also one of the original three states in the highly successful Cash and Counseling pilot program that is the equivalent of a Health Reimbursement Arrangement for disabled individuals on Medicaid. Instead of having to rely on the state to hire a provider, each individual gets a budget and can hire their own caregivers. Satisfaction rates with the program are up to 98 percent. More than two dozen states have either adopted or are soon to adopt models of care based on Cash and Counseling.

Finally, Governor Bush and his team have gone the furthest in achieving price and quality transparency with their must-visit websites http://www.floridacomparecare.com/ and http://www.myfloridarx.com/ Both represent a treasure trove of information on hospital quality information and prescription drug prices. Each site costs only about $200,000 per year to run so it is eminently affordable for any state to do the same. We are certainly not under the illusion that all Medicaid patients have Internet access, but starting the process of information dissemination is an important step.

Governor Fletcher in Kentucky just this month received preliminary approval for a comprehensive 1115 waiver that will alter fundamentally how Medicaid finances care for poor Kentuckians. The new program called *KyHealth Choices* will expand the range of choices available to disabled and frail adults in home and community-based settings. The program will permit up to four different plan choices for individuals including at least one option that is fully consumer directed. That plan will allow participants to access a

blended package of consumer directed benefits that will permit migration back to a more traditional agency model of care delivery if that individual chooses.

Another component of the *KyHealth Choices* is "Get Healthy Accounts" which will allow beneficiaries to earn extra benefits for meeting certain healthy practices such as annual exams and/or disease management protocols. The achievable benefits include credits for cost-sharing requirements, additional health care benefits, gym membership, and smoking cessation programs.

The Kentucky Department of Medicaid Services has also replaced its Medicaid information infrastructure to emphasize electronic billing, e-prescribing, and coordination of care via patient utilization review. The Kentucky legislature complemented this work last year by passing legislation to establish a statewide e-Health Network Board. Its goal is to bring together all of the major stakeholders in pursuit of advanced health information technology in Kentucky and the adoption of electronic health records.

In Colorado last year, the Democrat-led legislature and Governor Owens cooperated to exponentially expand that state's Consumer Directed Attendant Support program for the severely disabled. A small pilot project of 150 individuals that began in 2002 has proven immensely popular among beneficiaries and showed average annual monthly spending 21 percent under budget. Starting this year, the CDAS option will be extended to 33,000 Medicaid beneficiaries.

The Oklahoma Health Care Authority is making great strides towards Medicaid transformation as well. OHCA is streamlining the eligibility system with the goals of enhancing access to information about long-term care services to maximize individual choice and appropriate decision-making. OHCA also recently received approval for a HIFA waiver that will assist employees of small businesses (25 employees or fewer) with their share of health insurance premiums. This program is targeted at individuals who earn less than 185 percent of the federal poverty level who are not Medicaid eligible. Additionally, OHCA is making a firm push for more publicly-accessible data on patient outcomes and quality information.

In Tennessee, Governor Bredesen is undertaking a major effort to extend community health records to all 1.1 million TennCare beneficiaries. The program is now accessible to 2,500 physicians at 500 sites across the state with these figures on pace to double in 2006. This electronic infrastructure is expected to greatly enhance the coordination of care and cut down severely on waste, fraud, and abuse to the extent that savings of hundreds of million of dollars per year are entirely possible.

The Missouri legislature voted in 2005 to sunset their existing Medicaid program entirely on June 30, 2008. This is the most far-reaching effort in the country and demands a great deal of focus on what will appear in its place. The Missouri Medicaid Reform Commission released its 75-page report this month that contained sweeping recommendations to improve patient care by emphasizing a model of wellness,

prevention, and disease management. The Commission also recommended universal adoption of electronic health records and e-prescribing.

This Commission will be hearing from Idaho Governor Dirk Kempthorne tomorrow. Governor Kempthorne is spearheading a bold reform initiative characterized by sorting individuals on Medicaid by their health needs, rather than by complex federal categories that make the tailoring of benefits to each person more difficult. Governor Kempthorne and his team recognize that the elderly, individuals with disabilities, and the healthy poor have different requirements. The Idaho plan also contains personal health accounts to reward compliant behavior and a HIFA waiver to assist individuals employed by small businesses (2-50 employees) afford their employer coverage.

You will also hear from Governor Romney of Massachusetts tomorrow. He deserves substantial credit for coming up with one of the most unique plans in the country aimed at eliminating the problem of the uninsured by leveraging voluntary employer contributions and Medicaid dollars combined with an individual mandate to purchase coverage. There is considerable interest in this model nationwide.

Governor Vilsack and his team in Iowa are making similar strides toward electronic medical records to promote coordination of care and compliance. The Iowa Care program will pay for the health insurance premiums of members when their employer covers 50 percent of the cost.

The Texas legislature and Governor Rick Perry undertook a major overhaul of that state's health and human services department and Medicaid program in 2003. The goals were to consolidate agencies and streamline the eligibility process by utilizing one-stop shop call centers. Early evidence is that the system has become considerably more user-friendly and will save Texas taxpayers $646 million over the next five years.

Governor Granholm in Michigan deserves credit for emphasizing the need to promote health in children by suggesting the need to promote physical education in schools while stripping out the junk food. This is a low-cost approach that will pay huge dividends over the long run both in terms of dollars saved for the state and quality of life improvements for many thousands of Michiganders.

Medicaid programs across the country can learn from successful pilot projects in the private market as well. Among the most interesting is the Asheville Project in Asheville, North Carolina. This eight-year-old program focuses on tapping into the disease management expertise of pharmacists to improve the care of Asheville city employees. The level of care has improved markedly and overall outlays per diabetic patient declined by one-third.

Bridges to Excellence is a pay-for-performance program that reimburses doctors $100 per diabetic patient, provided that the doctors engage in proven practices of care management. The program is reported to yield savings of approximately $250 per patient. We are partnering with Bridge to Excellence in our Georgia Project to improve diabetes

care in that state in coordination with the state employee health plan and 14 major employers across the state.

The Silver Sneakers fitness program is aimed at senior citizens to promote physical activity and social interaction. It costs next to nothing and is so effective that members' high-risk sedentary behavior has declined by 70 percent. A full 44 percent of enrollees report increasing their physical activity by an average of two days per week. Claims costs of enrollees dropped by over 60 percent.

Medicaid programs across the country are at a major crossroads. It is obvious that the current state of affairs cannot continue, but it is not yet clear what the alternatives are. In my testimony today I have tried to offer a quick scan of the more promising initiatives unfolding in a number of states. But all states have a long way to go and can learn from the successes and failures elsewhere, both in Medicaid programs and in the private market. Open lines of communication among states, policymakers, and interest groups are critical so that adoption of worthwhile ideas happens as quickly as the discarding of ineffective ones.

Failure to aggressively seek out and quickly apply best practices costs lives. The stakes could not be higher. But there is plenty of room to be optimistic that Medicaid can be a program that improves quality of life in a manner that is fiscally sustainable.