State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

Thompson wants feds to take more responsibility for long-term care

As the nation heads toward the midterm elections of 2006 and what could be two lame-duck years for the Bush administration, major health system and Medicaid reform proposals have surfaced. A Medicaid Makeover plan proposed by former Health and Human Services secretary **Tommy Thompson** calls for the feds to take increased responsibility for planning, delivering, and paying for services to the elderly, especially long-term care services, while states take greater responsibility for caring for those younger than age 65.

Mr. Thompson introduced his four-element makeover plan at the National Governors Association annual meeting.

"Medicaid right now is a failing program," he told the governors. "It is costing too much. It does not adequately meet the health care needs of the diverse population it is meant to serve. And what's more, lines of responsibility are so crossed between the federal government and the state government that no one really knows who's in charge."

Mr. Thompson tells *State Health Watch* he decided to present his ideas in August 2006 because work on them had been completed, two

See ***Thompson*** *on page 2*

In a redesign of its Medicaid program, Idaho is poised to focus on preventive care, wellness

Idaho is redesigning its Medicaid program to provide individualized benefits to three groups of people — low-income children and working-age adults, individuals with disabilities or special needs, and elders.

Fiscal Fitness: How States Cope

State officials have said Idaho can't afford the escalating costs in the growth of expenditures for Medicaid. Since 1987, they said, Medicaid program expenditures have increased more than 17% a year. Rather than reduce services or cut enrollment, they said they want to redesign the program to make it consumer-oriented and promote preventive health care and wellness.

"By designing plans around similar populations, we can encourage people to improve their health," the officials said. "As an example, for healthy children and adults, we can offer incentives for mothers to take their babies to their health care provider for well-baby checks or immunizations. For people who are elderly, we can design a package that offers them supports so they can live in their homes as long as possible

See ***Fiscal Fitness*** *on page 4*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

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THOMSON
AMERICAN HEALTH CONSULTANTS

Thompson

Continued from cover

public hearings had been held, he wanted to bring them to the attention of the nation's governors, and he wanted to help influence considerations by the Medicaid Commission.

"I thought this was something the governors and the commission could look at and use," he says. "Also, I wanted to get our proposal out before the fall political campaigns heated up so there could be dialog about it as part of the campaign. These ideas will become fodder for the 2008 presidential campaign. Candidates have to be well versed on Medicaid. They need answers to the problems and it's important to get this information out and to be part of the dialog."

Four challenges, solutions

Working with the Deloitte Center for Health Solutions, Mr. Thompson has produced a white paper on "four challenges and potential solutions on the road to reform." He notes that as some states are beginning to recognize, what is needed is not a fine-tuning of the current one-size-fits-all Medicaid system, but rather 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 lifeline to a vastly diverse group of disadvantaged individuals, will continue to deteriorate," he says. "Medicaid stakeholders — patients, payers, providers, and governments — must all be engaged and be part of the solution."

In his white paper, Mr. Thompson focuses on four core challenges he says the Medicaid program faces:

1. Meeting diverse needs. How can Medicaid 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?

2. Empowering individuals. How can Medicaid more efficiently encourage individuals to play an active role in their health care?

3. Updating structures. What steps can be taken to update Medicaid payment structures and technologies?

4. Addressing the problem of the uninsured. What can Medicaid do to help address the problem of the uninsured?

Do what you know best

So Medicaid can better meet the health care needs of the four groups that dominate the Medicaid population, he says, states and the federal government should be able to focus on the populations they know best. That would mean having the federal government take greater responsibility for delivering and paying for services for the elderly, especially long-term care services, while states take on greater responsibility for caring for those younger than age 65. He also recommends a Medicaid program that is nimble enough to allow states to address the needs of different populations differently, creating options for families and targeting chronic and serious needs.

"States should offer Medicaid families more options for meeting their health care needs," Mr. Thompson wrote, "including helping families obtain commercial insurance by providing subsidies to cover the cost of participating in employer-based programs. States also should provide more coordinated, comprehensive, and targeted care for individuals with chronic needs and other serious illnesses,

through care management programs and other creative options."

Redefine federal and state roles

According to Mr. Thompson, the general concept in realigning government responsibilities would be to shift increased fiscal and policy responsibility for meeting the long-term care needs of the elderly to the federal government, while primary fiscal and policy responsibility for the acute care needs of all Medicaid beneficiaries, as well as long-term care services for the nonelderly would remain with the states.

"The realignment could be based on health care service, population, or a combination of the two," he said. "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 people to the federal government. The other end of this spectrum would be marked by shifting full responsibility for only specified long-term care services (for example, nursing home services) to the federal government."

While the Medicaid program was neither designed nor intended to become the largest primary long-term care program in the nation, Mr. Thompson said, in 2003 Medicaid payments accounted for 46% of all nursing home revenues nationwide and individuals with Medicaid coverage accounted for more than two-thirds of all individuals living in nursing homes. In 2002, Medicaid payments for individuals dually eligible for Medicare and Medicaid comprised 42% of all Medicaid spending, with 65% of that spending attributed to long-term care.

"Since the federal government presently spends significantly more Medicaid dollars on acute care than on long-term care, to remain whole, the states still will need to receive federal Medicaid funds following a realignment," Mr. Thompson said. "The funding mechanism selected will need to account for the fact that state spending on long-term care services vs. acute care services varies widely."

In terms of empowering Medicaid recipients to become more involved in their own health care, Mr. Thompson said a good first step would be to identify barriers now preventing them from taking this initiative. Steps also should be taken, he said, to ensure that each individual receiving Medicaid benefits has a health care home, since fragmented care often results in poor health outcomes, in addition to fostering frustration with a system that may discourage future utilization of services.

Mr. Thompson notes that health literacy programs, disease prevention programs, outreach and education programs, and flexible incentive programs should receive funding priority because everyone wins if the Medicaid population becomes healthier. "Individuals clearly reap the most rewards," he says, "but state coffers would benefit as well, since healthier individuals are generally less expensive to treat."

He suggests the federal government reward states that work to improve the health literacy of their patient populations, and states should in turn reward providers for such efforts. He also suggests the federal government require states to make disease management programs available to Medicaid recipients, and offer states financial incentives, such as enhanced matching, for services furnished in connection with such programs.

Mr. Thompson also calls for more patient outreach and education programs so individuals can learn about their own health care and status. States, he says, should be working toward educating patients on a variety of issues, including understanding risk factors for disease prevention; providing knowledge about specific diseases to sufferers, their families, and caretakers; and promoting healthier lifestyles. And he says healthy populations should be given an opportunity to exert more control over their health care expenditures, reflecting the private sector trend toward consumer-directed health care.

Mr. Thompson's third area of focus is updating core structures such as outdated Medicaid payment structures and technologies that end up causing increased costs and diminished quality. He calls for updating payment systems to reward quality of care rather than simply quantity of services, and says states should be encouraged to undertake eHealth initiatives to improve quality, safety, and cost-effectiveness across the Medicaid care continuum.

Finally, he says Medicaid is not doing its share to address the problem of the uninsured, and states must be encouraged to expand Medicaid coverage to lessen the strain on the health care safety net. He suggests states develop creative options for covering the uninsured through public-private partnerships and otherwise.

Helping his business interests?

Mr. Thompson's proposals have drawn some fire from critics who say they would help companies with which he is affiliated. The former Health and Human Services secretary is now on the board of Centene Corp., which operates Medicaid-funded HMOs in several states. His interest in seeing more Medicaid recipients in HMOs could help that company's bottom

line, critics told *The Washington Post*. He's also chairman of the Deloitte Center for Health Solutions, part of the Deloitte & Touche USA consulting firm that has contracted with states to help improve their Medicaid programs. He is a partner in the law firm Akin Gump, which has health care and insurance clients, and part-owner and board member of VeriChip Corp., which makes microchips that store data and can be implanted in humans. It could become a player in any move to expand electronic medical records.

Mr. Thompson has responded that his efforts to change Medicaid began "long before" his corporate relationships.

He tells *SHW* that while none of his proposals are new and all have been discussed before, they haven't been packaged in this way before and no one has taken an active interest in pushing them.

"I can't imagine we're going to be ignored," he says. "The governors are pushing for changes and Congress wants to do something."

But some observers question how much impact this proposal can have. Urban Institute Health Policy Center director **John Holahan** tells *SHW* he doubts the Thompson Makeover proposal will gain much political traction, although the Medicaid problem is a serious issue for states that deserves attention.

"It would cost the federal government probably $25 billion to $30 billion to shift the dual-eligibles," Mr. Holahan says, "and that's just not going to happen."

He notes that the National Governors Association had advanced the idea and then stopped talking about it because of the federal deficit and the realization that it is "not remotely likely."

Mr. Thompson's Medicaid Makeover proposal could play an important role in overall Medicaid reform, according to Mr. Holahan, but wouldn't be a total solution because it doesn't address other problems such as disparities between states and intergovernmental transfers. "It all depends on what your goal for Medicaid is," he adds.

Medical College of Virginia department of health administration associate professor **Robert Hurley** tells *State Health Watch* he also doesn't see much new in Mr. Thompson's approach.

"The notion of a state-federal 'swap' has a lengthy history and to date has not progressed," he says. "Perhaps the enhanced attention to the dual eligibles embodied in Part D and the Special Needs Plans indicates more appetite to consider putting funding together in a more rational way. But it looks like this would have significant federal budget implications and that would seem to be a nonstarter."

But Mr. Thompson says he's just getting started. He tells *SHW* he will be speaking out during this year's political campaigns and will be talking with individual governors to secure their support. And he plans to start working with members of Congress to find some leaders willing to turn his proposals into legislation to be introduced either as a standalone bill or amended into another bill.

Download Mr. Thompson's proposal and background information at www.medicaidmakeover.org. Contact Mr. Holahan at (202) 261-5666 or e-mail Jholohan@ui.urban.org. Contact Mr. Hurley at (804) 828-1891 or e-mail rhurley@vcu.edu. ■

Fiscal Fitness

Continued from cover

without having to move to a nursing facility. We know that one size does not fit all. By working together, we can design a system to meet people's unique needs."

Idaho is making its changes under provisions of the Deficit Reduction Act of 2005 that gave states many options for redesigning their Medicaid programs. In approving Idaho's plans, HHS Secretary **Mike Leavitt** said Idaho "is on the cutting edge in crafting Medicaid benefit packages to the needs of its residents. These changes make sense for beneficiaries and the very future of the Medicaid program."

CMS administrator **Mark McClellan** said the new targeted system "will be more efficient while meeting the specific needs of the people who count on it. We expect more states to follow Idaho's lead in redesigning their programs to give people access to affordable care that better reflects their own health needs and preferences. These changes will make Medicaid more sustainable without restricting eligibility or access to services that low-income and disabled individuals need."

The redesigned Medicaid program will offer:

• **The Benchmark Basic plan to serve healthy children and adults by covering most of the traditional Medicaid benefits except for long-term care, organ transplants, and intensive mental health treatment.** Children younger than age 19 will continue to receive all of these and other benefits through Medicaid's Early Periodic Screening, Diagnostic, and Treatment program.

• **The Enhanced Benchmark plan to serve individuals with more complex health care needs, such as the disabled and the elderly.** It will cover all traditional Medicaid benefits, including long-term or institutional

care. People enrolled in the Basic plan who need benefits not covered under that plan will be moved into the Enhanced plan.

• **The Coordinated Benchmark plan will include all the benefits of the state's traditional Medicaid program and will serve Medicaid enrollees who are also eligible for the Medicare program, known as dual-eligibles.** This group will be required to enroll in the Medicare Part B outpatient coverage plan and the Medicare Part D prescription drug plan.

All three plans will include some new benefits such as preventive and nutrition services and "preventive health assistance" to help the obese, smokers, and others adopt healthier habits.

The plan has drawn praise from the Medicaid commission that will be making recommendations to Congress on the best ways to revise the program.

In a presentation to that commission earlier this year, Idaho Gov. **Dirk Kempthorne** said Medicaid reform must come from the states.

"We are all aware of the problems many states have experienced by cutting eligibility and services for their Medicaid recipients," he said. "It's resulted in more emergency room visits, more expensive treatment, and more lawsuits. Compare that to what we've done in Idaho. When our budget problems forced holdbacks, we looked for ways to reduce spending with a minimal impact on our citizens. We focused on improving the management of Medicaid. And what have been the results? No cuts in eligibility. No cuts in services. More than $150 million in savings and better care for patients."

But Mr. Kempthorne said if the problems of the current Medicaid system are to be solved, it is necessary to turn the focus away from an antiquated, regulation-based system and toward one that focuses on results. He said his redesign will focus on results instead of rules, outcomes instead of cumbersome regulations. "It is a vision of what Medicaid should be," he declared, "not just what it's allowed to be under the current bureaucratic framework."

Key elements

While the three plans are at the heart of Mr. Kempthorne's proposal, there are other noteworthy elements:

1. He proposes providing a health risk assessment in the form of a comprehensive physical exam to ensure every participant has access to needed benefits. His budget recommendation includes increased provider payments to ensure every child will have a comprehensive check-up at the time of enrollment. Health assessments also will be completed for any adult who enrolls in the program and Medicaid will partner with Medicare for the elderly and dual-eligible populations.

2. For relatively healthy low-income children, there is a focus on primary care, prevention, and wellness.

3. There are efforts to eliminate barriers that prevent people with disabilities from seeking employment. And the plans are intended to enhance individuals' ability to choose and direct the services that are most appropriate under a model of consumer-directed care.

4. The program for the elderly is to focus on strengthening support services through family and informal caregivers and helping individuals stay in their homes and communities longer, rather than being forced to rely on more expensive nursing home care. This will involve some changes in federal Medicaid law.

5. A pilot pay-for-performance project is planned with the state's physician residency programs and community health centers. This will require a federal waiver.

6. A pilot program will test providing preventive health services in public schools. This will require changes in Medicaid law.

7. The reform proposal seeks to implement selective contracting strategies to help control Medicaid cost growth. The idea is to identify vendors to deliver medical supplies and save through volume purchasing. "States should have broad authority to employ the common network management tools — like private insurance plans do — to increase Medicaid's purchasing power and generate savings," Mr. Kempthorne said.

8. The governor proposed "common-sense, enforceable cost-sharing provisions such as copayments for certain services," saying they would address inappropriate emergency department utilization, inappropriate emergency transportation, non-preferred prescription drugs, and missed appointments with primary care providers.

9. Equalized eligibility rules between Title 19 and Title 21 children's programs to base different benefit packages on health needs as opposed to arbitrary distinctions based on income levels.

10. Use benefit plan design to address inappropriate service utilization.

11. Expand home- and community-based services to prevent or delay more costly institutional-based care.

12. Implement respite care programs and training for informal care providers to prevent or delay more costly institutional-based care.

13. Promote use of non-Medicaid financing programs such as reverse mortgages and long-term care insurance.

14. Enact 100% tax deduction for long-term care insurance at the

state and federal level.

15. Encourage individuals to transition from the last payment to their children's education savings account to the first payment toward purchase of long-term care insurance.

16. Allow all states to participate in the long-term care partnership program.

State officials said a set of "filters" will be used to guide decision-making in the modernization effort. Thus, changes will need to be holistic, to foster simplicity, to promote fairness, and to create value.

Not everyone is agreed the plan is sound. The Idaho Community Action Network (ICAN) issued a report, "Don't Waiver on Medicaid," opposing approval of the waiver needed to implement the proposal and has lobbied the state legislature against it.

ICAN says limiting health care benefits and making health care programs more difficult to access "will harm the health of Idaho's low-income families, people with disabilities, and the elderly." It says there are better ways for the state to address rising health care costs, including strategies for restraining the cost of prescription drugs, removing eligibility barriers, and making institutional care the last resort rather than the first resort.

At a rally at the state capitol, ICAN member **Jolene Poen** said her family lives on a very limited income. "If they impose premiums for my children's Medicaid, there is a very good chance we won't be able to afford them," she said. "We'll lose our health coverage and wind up uninsured with 250,000 other Idahoans."

The ICAN report cites statistics from states that have imposed premiums as a way of controlling Medicaid costs. It says in Oregon, after monthly premiums of $6 to $20 were imposed in 2003, more than half the affected people were disenrolled from Medicaid and overall 50,000 people lost their Medicaid coverage and two-thirds remained uninsured.

"The proposed waiver will shift costs to providers and counties," ICAN member **Terri Sterling** said. "More people will end up uninsured but still needing care, and we all pay for that care indirectly. The proposal will also endanger federal matching funds, since the state receives $24.44 from the federal government for every $10 it spends on Medicaid. This is a serious gamble for Idaho."

Information on the Idaho Medicaid reform proposal is available from the state on-line at www.healthandwelfare.idaho.gov and from the National Conference of State Legislatures at www.ncsl.org. Information on the Idaho Community Action Network position is available at http://icanweb.net. Download "Don't Waiver on Medicaid" at www.nwfco.org/pubs/2006-0208_Dont-waiver-on-medicaid_Gov-Kempthorne-webv.pdf#search=%22don't%20waiver%20on%20medicaid%22. ■

Patients say it's time for change in the health system

Patients surveyed by Harris Interactive for the Commonwealth Fund report experiences of wasteful, inefficient, or unsafe health care. Half of middle-income and lower-income families reported serious problems paying for care and insurance coverage, and three-quarters of all adults said the U.S. health care system needs either fundamental change or complete rebuilding.

The Commonwealth Fund's Commission on a High Performance Health System, which is making recommendations for an improved health care system in the United States, paid for the poll in hopes that its responses would provide insight for policy actions that are grounded in the daily realities faced by patients and their families.

Overall, commission officials said, there is strong public support for efforts to improve care coordination and access to information. There is a shared belief that expanded use of information technology, practitioner teams, and improved delivery of preventive care could improve the quality of care.

Substantial majorities of those surveyed believe it is important to have one place or doctor responsible for care and coordination and to have medical records easily accessible by patients and all their physicians. However, recent studies have shown that adults in the United States generally have short-term relationships with their physicians, often lack a regular source of ongoing care, and rarely have easy access to their own medical records. Only 37% have had the same physician for the past five years or more, and only 51% reported having access to their own records.

A majority of adults believe it is important to have access to information about the quality and cost of care, and most believe that quality and efficiency should influence the amount of payments made to physicians and hospitals. But the reality patients encounter is quite different. In a survey of individuals with health insurance, only 15% reported they had access to information on

quality and cost of care. And health insurance plans themselves often lack information on quality or outcomes of care over time, and are therefore unable to develop networks or incentives to reward and support clinicians who provide higher-quality, more efficient care.

While most adults surveyed view efforts to facilitate information exchange and practitioner teams as effective strategies to improve quality of care, the current environment is quite different. A 2003 survey of physicians found that only 27% used electronic medical records routinely or occasionally, and only 54% sent patients reminders about preventive care. One of three physicians practices in a solo office and about 25% are in groups of two to four physicians.

Many worry about cost, access

Affordability of care and insurance is a growing concern. In addition to concerns about costs, a high proportion of adults have serious problems getting timely care and reported spending time on paperwork and having disputes related to medical bills and insurance.

Reflecting their own negative experiences as well as worries about the future, fully 75% of all adults believe the U.S. health care system needs to be fundamentally changed or rebuilt completely. The commission said that negative view prevails across groups by income, insurance, and political affiliation.

Some 30% of adults believe the system needs to be completely rebuilt, while another 46% think the system requires fundamental changes. Only 20% of adults think the health care system works relatively well, with only minor changes needed. System views are reported to be remarkably similar across income groups and regions of the country.

More Republicans than Democrats (35% to 11%) see a need for only minor changes, but very large majorities of both parties call for fundamental changes or complete rebuilding. Strong negative views of the system were higher among those who reported having negative quality and care experiences.

The survey asked respondents to rate the importance of seven possible policy actions for the president and Congress — ensure that Medicare remains financially sound in the long term; control the rising cost of medical care; ensure that all Americans have adequate, reliable health insurance; lower prescription drug costs; improve the quality of nursing homes and long-term care; reduce insurance complexity; and reform the medical malpractice system.

Top four priorities

The top four priorities identified were ensuring that all Americans have adequate and reliable health insurance, controlling the rising costs of medical care, lowering prescription drug costs, and ensuring that Medicare remains financially sound in the long term. Commission researchers said the rank order was remarkably similar across income groups and regions of the country, but varied notably by political affiliation.

"These public views underscore the values and call for change underpinning the framework statement issued by the Commonwealth Fund Commission on a High Performance Health System," the survey report said. "The commission concluded that while the United States delivers some of the best medical care in the world, it falls far short of providing high-quality, safe, well-coordinated, and efficient care accessible to all Americans …. The United States is on the wrong track. Health care costs are escalating, and the numbers who are uninsured or underinsured are growing even greater. Patients and families want transformative change. Listening to the voices of patients about their care experiences provides a prescription for what is most ailing in our current system. Patients want a genuine system of health care, one where care is coordinated, no one falls through the cracks, and every one is secure in the knowledge that the best of American medicine will be there for them. It is a clarion call that should not go unheard."

In its framework report, the first of many commission reports expected to be released over the next few years, each increasing in specificity, commission members say the United States has some of the best-equipped hospitals and best-trained physicians in the world. "With much dedication to helping patients, they often provide extraordinary care. Nevertheless, the evidence clearly shows that, overall, the performance of the U.S. health care system falls far below the level it can and should achieve. On many dimensions of performance, from timely access to needed services to the deployment of health information technology, we lag behind other industrialized nations. Within our own borders, there are wide disparities from region to region and from state to state."

Despite spending more money on health care than any other country, the U.S. allocates resources wastefully and inefficiently, the commission said, failing to provide universal access to care and failing to achieve value commensurate with the money spent. Many patients receive treatments and procedures known to be ineffective, while other effective treatments are vastly underused. Tens of thousands die annually from preventable errors. Nearly half of all

adults worry they will not be able to pay their medical bills if they become seriously ill, will not get high-quality care, or will experience a medical error.

Goals of a high-performing system

To get discussion on its proposals started, the Commission on a High Performance Health System said the overarching mission of such a system is to help everyone, to the extent possible, to lead long, healthy, and productive lives. To fulfill that mission, such a system must:

- commit to a clear national strategy for achieving the mission and establish a process to implement and refine that strategy;
- deliver care through models that emphasize coordination and integration;
- establish and track metrics for health outcomes, quality of care, access to care, population-based disparities, and efficiency.

"At present, no organization or body, except Congress, can commit to a national strategy," the commission said. "Options could range from relatively modest steps, such as a reorganized committee jurisdiction structure, to more far-reaching steps, such as the devolution of substantial congressional authority to a Federal Reserve-like structure for health care, which would set rules for public and private stakeholders."

A high performance health system, according to the commission, is designed to achieve four core goals: 1) high-quality, safe care; 2) access to care for all people; 3) efficient, high-value care; and 4) system capacity to improve.

While it plans to become much more specific in future reports in terms of recommendations for change, the commission has said it believes a mix of private and public financing, organization, and delivery will continue, at least for the foreseeable future. A high-performance health system for the United States will likely combine market forces and public policy to achieve its goals, the report said. America's challenge is to find a way to benefit from what markets can provide while pursuing alternative strategies to achieve what markets cannot.

Targeting improvement

As its next step, the commission is working on national and state scorecards to measure U.S. performance against specific benchmarks. It said those documents will be instrumental in setting specific targets for improvement.

The next step will be to envision how each stakeholder in the system is to be accountable to others, and how that accountability can be brought about. For example, the commission said, health plans should be accountable for ensuring that benefit packages include the right care; providers should be accountable to patients and to purchasers for providing the right care; employer purchasers should be accountable for providing employees with the tools to make wise choices among plans, providers, and treatments; and patients should be accountable for actively managing their health and complying with effective treatments.

Initial steps that can and should be taken, the commission said, include:

1. Expand health insurance coverage. The commission views expansion of insurance coverage as a necessary, but not sufficient, step toward universal participation in the health system.

2. Implement major quality and safety improvements. This could include promoting use of evidence-based medicine, promoting effective chronic care management, reengineering delivery within and among provider organizations, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings.

3. Work toward a more organized delivery system that emphasizes primary and preventive care that is patient-centered. While strategies for improving quality and safety focus on creating better systems within and among health care delivery organizations, the commission said patient-centered practices should also be emphasized. And although specialty care is essential, there is increasing evidence that a high performance health system needs to focus on primary care. The commission said the key levers for promoting change are benefits design, work force training, and payment policy.

4. Increase transparency and reporting on quality and costs. Public reporting of information on the performance of health plans and providers can spur improvements in quality and efficiency, primarily by helping consumers make more informed decisions and by stimulating plans and providers to be more accountable for their results.

5. Reward performance for quality and efficiency. The commission said the health care payment system should be restructured so providers are reimbursed based on the quality of care they provide. Purchasers, both public and private, can improve quality and efficiency by building performance standards into health plan contracts and developing pay-for-performance programs that reward quality and efficiency in providing acute and chronic episodes of care.

6. Expand use of interoperable information technology. Computerized order entry systems

and electronic health records developed at the organizational level can help to reduce costs and improve safety and efficacy. But for the health system to maximize benefits from the individual systems, innovation must focus on linking all pieces into an interoperable network.

7. **Encourage collaboration among stakeholders**. The commission said it is necessary to create a culture of high performance in which all parties share a vision of bringing high-quality health care to every person. It is particularly critical for the public and private sectors to work together.

"The commission will explore alternative models and organizational structures for setting and updating our national strategy and for measuring and tracking our performance," the report concluded. "Ultimately, the commission seeks to define the specific policies and practices that can help the nation attain this vision, and it plans to develop and disseminate recommendations to the nation. The commission believes that the nation can and must do better, and it is committed to action."

Flexibility ahead?

Meanwhile, three current or former members of the White House Council of Economic Advisors discussed health care costs at an American Risk and Insurance Association forum and created an impression that the continuing national debate over health care entitlement programs could end up being more flexible than in the past.

"We spend more than twice as much of our gross domestic product on health care as our comparable trading partners in the Organization for Economic Cooperation and Development and it doesn't seem as though our health outcomes are twice as good," said recent economic advisors appointee **Katherine Blacker**. She also noted a "dramatic variation" in how much is spent per Medicare beneficiary across the country and said, "The areas where we are spending more money per Medicare beneficiary are less likely to get what is fairly universally acknowledged to be higher-quality care."

Brookings Institution researcher **Peter Orszag**, a member of the council during the Clinton administration, said the disparity in Medicare spending suggests it is possible to constrain health care cost growth in ways that don't materially adversely affect health outcomes. He also called for more efforts such as those in West Virginia to create a "compact of personal responsibility."

"Basically, you need to take steps to take care of yourself and actually show up for medical appointments and vaccinations and what have you, and in exchange we'll provide health care," he said. "In the absence of the personal responsibility component, we could be wasting a lot of money."

Douglas Holtz-Eakin, an earlier Bush administration appointee to the council, said the United States must decide "the degree to which we want to continue to have pay-as-you-go social insurance-style systems, vs. systems that look more like self-insurance."

Making change

Commonwealth Fund Commission on a High Performance Health System executive director **Stephen Schoenbaum** tells *State Health Watch* he hopes to be able to accomplish change even within the current political environment.

"The commission hopes a lot will be accomplished at the national level and also in the private sector," he says. "We're not considering that in two years this administration will turn over, but there's also enough involved in what we're doing that this is a good time to start thinking about 2008."

Mr. Schoenbaum acknowledges that as the first document the commission has issued, the framework "is pretty general in setting out the problem and stressing the need to redesign the health care system. I expect a significant amount of activity over the next couple of years to be much more specific."

Progress unlikely

Medical College of Virginia department of health administration associate professor **Robert Hurley** tells *State Health Watch* that what the Commonwealth Fund's commission has produced so far seems to be "more exhortation for action" rather than concrete, actionable proposals. And he's pessimistic about the political will to address the issues.

"I think the prospect of substantial Medicaid or health reform in general is unlikely in the next two years," he says. "Even if the fall 2006 elections lead to a shift in control, Democrats are likely to tackle less controversial issues initially as they try to solidify their position. I also think that if the economy softens, as it seems to be on the edge of doing, then we can probably forget about anything particularly ambitious. I'm sorry to sound so skeptical but the war, the deficit, and the ideological divide each seems a stopper in its own right, and rolled together they cast doubt on any constructive reform in the near term."

The commission's reports are available at www.cmwf.org. Contact Mr. Schoenbaum at (212) 606-3800. Contact Mr. Hurley at (804) 828-1891 or e-mail rhurley@vcu.edu. ■

NGA recommends states promote healthy behaviors

With the nation's health care costs running at nearly $1.8 trillion per year, of which some $21 billion is used to treat chronic and often preventable conditions such as diabetes, cancer, and cardiovascular disease, the National Governors Association (NGA) says states have an opportunity to save billions of health care dollars each year by promoting healthy lifestyles among Medicaid beneficiaries.

An issue brief, "Creating Healthy States: Promoting Healthy Living in the Medicaid Program," issued by the NGA Center for Best Practices, says governors have opportunities to use three basic strategies to encourage healthy behaviors — providing wellness incentives for beneficiaries, offering tools and incentives to engage Medicaid providers, and targeting and tailoring Medicaid benefits to wellness. New flexibility granted states by the Deficit Reduction Act of 2005 is helping make these opportunities possible, the brief says.

The Deficit Reduction Act eliminated the requirement that certain efforts be implemented statewide, enabling states to target alternative benefit packages to specific subsets of Medicaid beneficiaries in the neediest regions. It also eliminated the so-called comparability requirement, allowing states to tailor benefit programs and services to meet the health care needs of different population groups.

Benefit changes that target and tailor Medicaid benefits may be approved through the State Plan Amendment process. However, because the Deficit Reduction Act applies exclusively to current eligibility groups, states cannot use the law to expand eligibility to new populations. In addition, new benefit packages must be actuarially equivalent to one of the specified benchmark options.

NGA said preventive care and counseling yield substantial benefits for state budgets and patients. Research shows investments in disease prevention and health promotion strategies can result in financial returns for states. In 1998, according to the issue brief, North Carolina implemented disease management program strategies for Medicaid beneficiaries suffering from diabetes, asthma, and cardiovascular diseases through the state's primary care case management program. A 2002 evaluation of the expenditures and use of services among diabetic and asthmatic Medicaid beneficiaries revealed monthly savings of $21 per member. And additional research has demonstrated that diabetes management services yield a net benefit of $2,702 per enrollee compared to traditional care, with the cost of services ranging from $42 to $84 per year.

"Governors have opportunities to cut costs while promoting healthy living practices among beneficiaries through provider and enrollee initiatives, care coordination, and disease management strategies," the Center for Best Practices said. "Experts have concluded moderate weight loss, exercise, and smoking cessation strategies can save billions of health care dollars each year. These efforts can reduce the number of healthy people who develop disease and the need for health care services among people who already have a chronic condition."

The Center quotes Centers for Disease Control and Prevention statistics to make the point. Thus, it is estimated that lifetime medical costs for an overweight person who sustained a 10% weight reduction would decrease by $2,500 to $5,300. If 10% of adults began a regular walking program, an estimated $5.6 billion in heart disease costs could be saved annually. Medicaid could save almost $3.50 in averted neonatal medical expenditures for every $1 spent on counseling pregnant smokers to quit. And states can reap additional benefits through multicomponent programs within and beyond Medicaid, NGA said.

The NGA report said state efforts to provide incentives for healthy behaviors are quite new, but the private sector has used them in employee wellness programs and health plans.

• **West Virginia**. West Virginia is promoting healthier living among Medicaid beneficiaries by offering enrollees an optional, extended benefits package including services not traditionally offered, such as tobacco cessation treatment, nutrition education, diabetes care, chemical dependency treatment, mental health services, cardiac rehabilitation, chiropractic services, and dental care. To gain access to the expanded services, Medicaid recipients must agree to attend scheduled preventive health visits and take medications as directed. Those who choose not to sign the agreement will receive the standard Medicaid benefits package. Those who don't follow the agreement may face disincentives.

• **Florida**. A Florida waiver program is piloting promotion of healthy living through incentives for enrollees who pursue healthy behaviors through preventive services and reduce the risk of poor health outcomes. The pilot will assess a

risk-adjusted premium reflecting each beneficiary's health status. Recipients enrolling in customized new health plans will receive monetary incentives for participating in healthy activities such as smoking cessation, annual checkups, and disease management programs.

• **Indiana**. The Medicaid program has worked with the state Health Department to develop the Indiana Chronic Disease Management Program for Indiana residents with chronic conditions. The program provides a number of services and support programs to help beneficiaries with diabetes, heart disease, asthma, and kidney disease.

• **North Carolina**. In 1998, North Carolina enhanced its basic primary care case management program, Carolina Access, by working with local physicians, hospitals, and public health and social service providers to improve the quality and reduce the cost of caring for Medicaid beneficiaries. Under Community Care of North Carolina, 15 local provider networks throughout the state collaboratively develop care and disease management systems to support beneficiaries. The North Carolina Medicaid program integrates disease management strategies, public health practices, provider groups, and social services to improve beneficiary health by leveraging access to programs in the state.

North Carolina also has been successful in providing access to health promotion and disease prevention by paying primary care providers at rates similar to those in the private sector.

• **Illinois**. Illinois is promoting important developmental screening tools to identify areas needing preventive or other health services. Officials said this approach of early identification, health promotion, and intervention can improve health outcomes and identify problems before they can affect development. The state provides an extra payment to pediatricians for using a developmental screening tool in addition to the standard well-child exam payment.

• **Georgia**. Although not a Medicaid program, Georgia recently launched a statewide effort to provide financial bonuses to doctors who improve care for more than 500,000 residents with diabetes. Physicians who choose to participate in the incentive program will be evaluated on how well they improve care for patients covered by the Georgia Health Benefit Plan, which covers 640,000 state employees and retirees.

• **Idaho**. Idaho is taking advantage of Deficit Reduction Act flexibility to create benefit packages targeted to the health care needs of different populations enrolled in the state program (**see cover story**). Beneficiaries are offered three benchmark plans providing specialized care for enrollees under a primary care case management program — Basic Benchmark Plans for healthy, low-income children and working-age adults; Enhanced Benchmark Plans for individuals with disabilities and special medical needs; and Special Coordinated Plans for the elderly and dual-eligible recipients. Idaho officials hope to incorporate health risk assessments and other screening procedures into the program to help match beneficiary needs to a specific plan's benefits package.

• **Kentucky**. Kentucky was the first state in the nation to provide a comprehensive plan to redesign its Medicaid program under Deficit Reduction Act provisions. Medicaid beneficiaries are offered one of four benchmark plans — Family Choices for healthy children, including SCHIP recipients; Comprehensive Choices for elderly individuals who need nursing facility care and individuals with acquired brain injuries. Optimum Choices for individuals with mental retardation and developmental disabilities in need of long-term care services; and Global Choices for the general Medicaid population, including most adults, foster care children, and medically fragile children.

The NGA Center for Best Practices says Medicaid programs play a key role in providing critical health services to a vulnerable population and could make a major contribution to efforts to achieve better health nationwide. The Deficit Reduction Act of 2005 is seen as expanding state opportunities to assemble a coherent wellness strategy, pilot innovative approaches, and target efforts to those Medicaid recipients with the greatest need and largest potential benefit. As the economic returns on the disease prevention strategies and health promotion services emerge, it says, they will become even more attractive to states facing the rising costs of treating chronic diseases.

NGA senior legislative associate **Jennifer Michael**, who helped develop the Center for Best Practices document, tells *State Health Watch* NGA believes states should take steps to save money and improve

This issue of *State Health Watch* brings you news from these states:

quality, even while working toward broader reform.

Meanwhile, former Secretary of Health and Human Services **Tommy Thompson** has brought forward a plan for Medicaid reform through his Medicaid Makeover effort sponsored by the Deloitte Center for Health Solutions (**see related story on cover**). The project brings together legislators, regulators, advocates, and health care experts to discuss and explore best practices.

"Medicaid is the single largest spending item in state budgets," Thompson said. "In half of the states, Medicaid spending exceeds 20% of state appropriations. Medicaid is now the largest single item in overall state budgets, surpassing elementary and secondary education. The fact is that states simply can't afford to meet the increasing costs, forcing states to limit access to critical health care programs."

So far, Thompson has hosted Medicaid Makeover: Learning What Works summits in Atlanta and St. Louis. "We need to change health care in America and Medicaid Makeover creates a platform that will allow us to see what works and what needs an overhaul," Thompson said at the first program in Atlanta. We need to make Medicaid nimble enough to allow states to address the needs of different populations differently. Right now, the lines of responsibility between the states and the federal government lead to confusion and inefficiency. Without prompt, creative, and comprehensive action, this complex and unwieldy program that serves as a lifeline to a vastly diverse group of disadvantaged Americans will continue to deteriorate.

And the four-term Wisconsin governor told the St. Louis audience it would be "great if governors would take pride in bragging about the health of their states. I'd like to envision a time when governors compete to see which state can vaccinate the most number of children, or have the least number of smokers. We need to manage health more than just manage care. Right now, the states don't have enough flexibility to develop innovative Medicaid programs that tackle prevention because they are weighed down by the financial burdens of treatment. This needs to change."

Download the NGA recommendations at www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=c067a8693b0bc010VgnVCM1000001a01010aRCRD. Contact Ms. Michael at (202) 624-5300. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Faulty billing cost: $56.3M MaineCare's problems persist

AUGUSTA, ME — The repair of the faulty billing system that processes Maine's Medicaid payments remains a protracted work in progress, along with the resolution of the considerable chaos it has created. State officials say the problematic computer system, which has wreaked havoc for health care providers and their bookkeepers since January 2005, is expected to be working correctly sometime in the summer of 2007, at an estimated total cost of more than $56.3 million in state and federal dollars. The original contracted cost for the new system was $21.6 million. More than 262,000 Mainers, almost a quarter of the state's population, are enrolled in MaineCare. According to **Brenda Harvey**, commissioner of Maine's Department of Health and Human Services, the computer system is currently processing correctly upwards of 90% of new claims from the thousands of doctors, dentists, therapists, home care providers, and others who provide services through MaineCare, as the state's Medicaid program is called. But that means that up to 10% of claims are not processed correctly, adding each week to the more than 180,000 claims that remain unresolved from earlier failures.

— *Bangor Daily News*, 8/23/06