Testimony to the Special Committee on Healthcare Facilities

Missouri House of Representatives

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Chairman Schaaf and Members of the Committee, thank you for the opportunity to be here this evening to offer my thoughts on how to create a 21st century intelligent Medicaid system. There is no doubt in my mind that a properly-designed Medicaid program will improve health outcomes at the same time it lowers overall cost. The key to achieving these twin goals simultaneously is to establish the right incentives for plans, providers, and individuals on Medicaid.

I last offered official testimony here in Jefferson City back on September 12, 2005 to the Missouri Commission to Reform Medicaid. I have included a copy of that testimony for the record. Since that time there has been significant debate and legislative action on this topic, and now you are in the homestretch. The work you are doing here is of great consequence and it is being watched by state policymakers across the country. The new Medicaid you create will become either a model for 49 other states to follow or a cautionary tale of what others should avoid. You have the power to dramatically improve the health of poor Missourians in a manner that is fiscally sustainable for Missouri taxpayers.

It is critical to begin this testimony by pointing out that each individual's health status is determined more by diet, exercise, stress levels, and family and community situations than it is by access to medical technology and healthcare providers (I refer you to the accompanying one-page chart compiled by Dr. Alvin Tarlov). Thus a truly comprehensive approach to improving the health status of poor Missourians would go far beyond just tweaking access to medical professionals, and include promotion of such things as physical education and proper food in elementary and secondary schools. Please keep this in mind as you think through efforts to make Missourians healthier. If your sole focus is on treating and managing disease instead of pre-empting it, then you will only be dealing with the symptoms of ill health, and not the root causes.

This evening, however, our focus is on how to improve Medicaid. Let us start with a clearly defined vision of a desirable Medicaid program. If we can agree that the following description is one that everyone likes, then we can work backward from there to outline the right steps necessary to arrive at our shared goal.

Do you want the following in your new Medicaid system?

- Higher reimbursements for providers
- Better rural access
- More use of preventive care/less use of emergency rooms
- More providers participating in the program
- Satisfied providers
- Satisfied Medicaid beneficiaries
- Lower per-member, per-month costs for each Medicaid beneficiary
- Technology that spots fraud and abuse in near real time

Arizona

There exists a Medicaid program that meets these standards. It is the Arizona Health Care Cost Containment System (AHCCCS). Arizona was the last of the 50 states to join the federal/state Medicaid program and did so under an 1115 waiver in the early 1980s. Arizona's program is unique. It also works. (You can easily go on-line at the CMS website to find Arizona's waiver and subsequent amendments in the last 25 years if you want the precise language of their program.)

Arizona's program features the following highlights. I am indebted to Tony Rodgers, Arizona's Medicaid director, for sharing these points with me last week.

- Arizona reimburses primary care and specialist physicians at one of the highest rates in the country and hospital outpatient reimbursement is at or above Medicare rates. (They have not done a comparison of hospital inpatient rates so therefore cannot say.)
- Good rural access as a result of network requirement on participating plans.

- Commercial enrollees and the uninsured both have ***higher*** rates of ER use than AHCCCS.
- According to 2006 surveys of AHCCCS contracted providers: Primary care physicians have a 77 percent satisfaction rate; specialists 75 percent; dentists 85 percent. Overall provider satisfaction rates in Arizona toward commercial health plans is 63 percent, versus 76 toward AHCCCS.
    - 85 percent of Arizona healthcare providers participate in AHCCCS
- AHCCCS has the fourth-lowest per-member, per-month cost of all state Medicaid programs and the lowest per member per month pharmacy cost, according to a Lewin report.
- AHCCCS beneficiaries' overall satisfaction rate was 87 percent among adult Medicaid beneficiaries and 91 percent with parents of children on AHCCCS.

How do they do they accomplish all of this in Arizona?

Arizona uses at-risk managed care plans that actively manage utilization. This is the key – allowing the plans to manage utilization. This permits plans to assign a primary care provider to all beneficiaries and put a heavy emphasis on preventive care. By cutting out uncoordinated care often delivered at high cost emergency rooms, not to mention massive amounts of fraud, plans can reimburse providers at higher rates for appropriate and effective care.

The alternative to an Arizona-style system is one in which Medicaid reimbursement rates are determined not by what is the most cost-effective care, but by whichever special interest group currently has the best lobbyists and access to key policymakers. Unfortunately, that describes the vast majority of Medicaid programs across the country and it is the proven recipe for failure.

Arizona has eight managed care plans across the state providing acute care and seven in the long-term care market. There are no statewide plans, just regional competition centered in Phoenix and Tucson and then rural areas (similar to Missouri with St. Louis, Kansas City and smaller, rural areas). The AHCCCS program specifically includes the Aged, Blind, and Disabled population that is a very large chunk of the overall Medicaid budget in all states. One of the major shortcomings of the recently-passed Senate legislation is carving out the ABD population. It is among this group that there is the greatest potential for improved patient outcomes at significantly lower cost.

It is worth mentioning that Arizona has seen its overall budget devoted to Medicaid shoot up over 40 percent from 2000 to 2005. This was the not the result of how the program has been run. Instead it was due to massive increases in new enrollees, mostly brought on by a ballot initiative in 2000 that dramatically expanded eligibility for Medicaid. However, Arizona still spends far less on Medicaid as a percentage of its overall budget than does Missouri. But the Arizona experience is yet another example of what happens when voters and/or policymakers feel generous in times of budget surpluses (times which are always temporary). The long-term fiscal pressures are left to future legislatures and governors to fix.

The next quantum leap in Arizona will be the widespread use of interoperable electronic health records. This will be a big advance in the ability of providers and plans to have at their fingertips each patient's medical history in order to provide and achieve better care. Tony Rodgers and his team are actively working with the commercial sector in Arizona and 13 other states to develop common standards.

Florida

Former Florida Governor Jeb Bush led the most sweeping changes to any state Medicaid program since 1965. He started this effort by making Medicaid reform a top priority, starting back in the summer of 2004. In January of 2005, he released a twenty-page outline of ideas. The Florida legislature held hearings the entire session that year and agreed upon a plan of action.

Florida's new Medicaid began in the summer of 2006 in Broward and Duval counties. Surprising many supporters and critics, there are 18 plans currently participating in those two counties for 170,000 beneficiaries. The next phase of roll-out begins in July 2007 for three rural counties – Nassau, Clay, and Baker, which combined have only 25,000 Medicaid beneficiaries. In these counties, where there had been no managed care organizations previously, four plans have submitted applications to participate – two HMOs and two Provider Service Networks. To slightly modify the famous line from the movie *Field of Dreams*, "If you build it right, they will come." And seeing as Florida Medicaid will issue report cards on participating plans, all will know who is doing it right and who is not.

Among the more innovative features of the Florida model are the "Enhanced Benefit Accounts" that allow individuals to earn dollars for complying with treatment regimens, not missing appointments, and achieving certain health goals. This is highly innovative policy and tracks some of the early pay-for-compliance schemes we are witnessing in the private sector. In the private sector, plans like Lumenos and Alegent Health Systems (the latter based in Omaha, Nebraska) are demonstrating better health at lower cost by leveraging creative incentives for weight loss and the treatment of diabetes. Lumenos actually saw an 8 percent decline in overall costs for 40,000 enrollees last year. Alegent saw a 1 percent decrease. Both were achieved by getting better health outcomes.

Florida is only scratching the surface in how incentives might work with Medicaid beneficiaries going forward. Please see the accompanying slide deck from the Gallup organization that was completed in September 2006 for the Center for Health Transformation's Second Annual "Creating a 21st Century Medicaid System" event. The Gallup survey shows that people on Medicaid are very open to changing their health behaviors and think that proper incentives would inspire positive change in their lives.

The launch of Florida's reform efforts were of course met with promises of doom and gloom from naysayers. In fact, there have been only 10 formal complaints from Medicaid

beneficiaries in Broward and Duval counties. Five of those were unrelated to the new program and most of the rest were about Medicare Part D.

For significantly more detailed information about Florida's Medicaid program, please see the slide deck presentation dated December 2006. I also wish to extend my thanks to Florida Medicaid Director Tom Arnold for sharing his thoughts and ideas with me over the phone last week.

A properly transformed Medicaid would leverage the best features of Arizona and Florida – at-risk health plans that have the ability to actually manage utilization, combined with the flexibility to individually tailor incentives for compliance.

You can't manage what you can't measure

We live in a world of e-Bay, Expedia, on-line banking, email, instant messaging, and cell phones with video. There is absolutely no reason that this level of real-time technology cannot exist in Medicaid to weed out fraud and abuse. Have you ever heard of any McDonald's franchise selling one thousand phantom Big Macs in a day? How about Wal-Mart selling one thousand phantom hammers? Or UPS billing for one thousand phantom packages?

It simply doesn't happen because sophisticated companies with the right incentives have extremely limited fraud, waste, and abuse. Contrast this with Medicaid. Consider the following examples that we uncovered in a recent cursory scan of Missouri Medicaid data:

1) A 47-year-old woman with bipolar disorder and anorectal pain:

- $15,551 in medical spending
- $180,501 in pharmacy spending
- $156,063 of the pharmacy spending was for Oxycodone and Actiq (fentanyl/narcotic lollipops) with all except three prescriptions *from the same provider*

2) A 60-year-old man with diabetes, renal failure, coronary artery disease, and congestive heart failure – very sick with no continuity of care to speak of:

- 11 hospital admissions
- 25 ER visits
- *Only 4 office visits*

3) The most expensive 44,000 people in Missouri's Medicaid program cost an average of $84,000 each. Five percent of the Medicaid population accounts for 45 percent of the total expenditure over a two-year data period.

4) There were 514 people who received *more than 70 opiate prescriptions.*

5) There were 32 people with more than 100 ER visits, including one with 240 – a 39-year-old man with diagnoses of diabetes and headache:

- Medical Cost: $25,300
- Pharmacy Cost: $14,600
- Opiate cost: $7,500
- *Number of ER Visits 240 (mainly for headaches)*
- Number of Office Visits: 31

6) One patient had over $2 million in claims over a two-year period.

Required: Interoperability of Data Systems

Three departments in Missouri interface with Medicaid beneficiaries – the Department of Social Services, the Department of Mental Health, and the Department of Senior Services. Those three agencies have over 15 different computer systems that cannot talk to each other. This is only a baby step ahead of stone tablets.

In a transformed system, not only would all three agencies communicate, they would be in seamless communication with other agencies that may touch a particular low-income individual, such as the Department of Corrections and the Department of Elementary and Secondary Education.

Governor Richardson of New Mexico has a new program in place that involves the coordination of care throughout 17 different agencies. Departments as diverse as Indian Affairs, Transportation, Health Services, and the Mortgage Finance Authority now talk to each other in order to create a comprehensive plan of care for each individual and/or family. Only when the most complete picture of an individual is available can the most appropriate assistance be delivered.

It is worth noting that the Office of Personnel Management that runs the Federal Employee Health Benefit Program for nine million federal employees, their dependents, and retirees is highly successful despite a staff of two hundred. Regardless of where a federal employee lives in the country, he or she has at least eight plans from which to choose. He or she is also able to change out of a plan for any reason each December. Contrast that with what you know to be true about how Medicaid operates in Missouri. Creating the proper expectations and oversight is the answer, not attempting to actually run the program.

Conclusion

The good news is that there are successful Medicaid programs operating across the country that you can emulate. You can pick and choose the best features of properly functioning Medicaid systems and combine them to create the best Medicaid yet. It is also good news that there are many people and organizations across the country who

stand ready to help. The bad news is that time is short and heavy doses of political will are required. By definition, any reform of real significance will rattle the status quo. But we know the status quo to be the problem. The question now on the table is if getting to real results matters.