



Testimony to The Missouri Commission to Reform Medicaid

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*“One cannot solve a problem with the same thinking that created it.”
-Albert Einstein*

The mission of the Center for Health Transformation is to create a responsive 21st century intelligent Medicaid system that leverages the most cutting edge technologies to provide better health outcomes at lower cost. Our stated goals are as follows:

- Eliminate racial and socio-economic health disparities
- Make the individual patient the center of health decision-making
- Leverage Medicaid funding 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 healthcare

To begin, it is important to restate a very obvious point. Medicaid is about serving the health care needs of low income people who cannot afford to pay on their own. This simple observation must be made at the outset because it is too often forgotten in the political arena as powerful special interests fight for their slice of the Medicaid budget and the institutionalized bureaucracy fights to justify itself. Actually improving the health of low income individuals ends up an afterthought.

The new motto of Missouri Medicaid might become, "Patients first." When any individual or organization makes a suggestion on how to improve the delivery of care to Medicaid patients, ask them specifically how their idea improves the health of Medicaid patients. And because we live in a world of limited resources it is important that their suggestion improve health at lower cost. You will be pleasantly surprised by the vast array of options that meet these twin criteria. The trick will be to create a system that quickly welcomes and incorporates these advances and does not stymie them.

There is only one way to truly transform Medicaid – to affect behavior change at the patient level. Everything else is window dressing. The solutions du jour – limited drug formularies, reimbursement rate cuts to providers, cutting eligibility, certificates of need, or begging the federal government for more dollars will not solve your problems. They will, at best, merely postpone the problems until they are bigger and more difficult to solve.

Individuals must think and act differently with regard to their health. New and creative incentives for individuals to meet various health metrics must be launched. This is particularly important for high cost patients with multiple chronic conditions. Treating them quickly and effectively not only lowers overall cost, it improves their quality of life. If done correctly it will reintegrate them back into the mainstream. This will be discussed in more detail later.

The purpose of my testimony today is to establish a vision for a 21st century intelligent Medicaid system. If we can agree on where we need to go, then getting there will be easier. I will follow that by discussing some of the work being done in other states. Finally, I will briefly touch on a critical, but overlooked, piece of the Medicaid puzzle which is the creation of an organizational structure that actively seeks out best practices and quickly adopts them. Bureaucracies are necessarily hostile to innovation because it threatens their existence. Medicaid is rife with bureaucratic red tape and institutional resistance to doing things differently. The status quo will be upset as progress is made. If done correctly, "But that's the way we've always done it," will never be heard again. You can compile the longest and most impressive list of the best ideas ever seen. But they are worthless if they are not implemented.

It is important to keep in mind that good health is cheaper. The most effective way to save money in this debate is to change behavior so that people do not get sick in the first place. That is why a key part of the long term solution to Medicaid costs is to strip all the junk food out of schools and require physical education in grades K-12. No state is serious about changing a sedentary culture that leads to obesity, teenage onset type-2

diabetes, and a range of other ailments unless it actively promotes rigorous physical activity and a healthy diet. After all, these always have been and always will be the two best paths to health.

I strongly urge that Medicaid reform become the top, personal priority of the governor. An effort “at the highest levels,” is not good enough. This is an effort that demands hands-on supervision by the chief executive. It doesn’t require the governor to be a personal expert in Medicaid. It requires him to create a culture of urgency and competence that is dedicated to results regardless of what the special interests may say. Revolutions come from the outside. A newly elected governor fits that mold.

Changes in Medicaid should mirror the larger shift happening in health care financing. This is the move to consumerism and away from passive, uninformed patients with negligible financial considerations accepting whatever care came their way. Contrary to myth, people are immensely capable of learning about prices and quality and making purchases based on that information. It is beginning to happen in health care too.

We saw a similar shift in retirement plans beginning in the 1980s when companies began moving from a defined benefit to a defined contribution. As far as the younger generation is concerned, that shift is complete. Imagine telling a 22 year old about her defined benefit retirement plan when she leaves her company at age 65. She would think you are from Mars. She wants to know what the company will match her 401k. This is despite the stock market volatility of the previous few years. People’s ability to make choices is almost always underestimated by the political class.

The good news is that Missouri is on the right track. This Commission and this administration have committed themselves to a fundamental transformation of the Medicaid program. If done correctly, the biggest winners will be people who rely on Medicaid for their healthcare needs.

What is the 21st Century Intelligent Medicaid System?

If we were sitting here 20 years ago describing conveniences available to nearly everyone in the year 2005, few would believe it – the Internet, Ebay, Amazon, Expedia, Google, on-line bill paying, cellular phones that double as cameras, ipods, high definition digital television with Tivo and DVD players, just to name a few. All of this would have sounded like a fantasy back in 1985. The next 20 years will see equally remarkable advances that almost none of us can predict. The point is that we can look forward to even more extraordinary advances and our programs and institutions must be set up to embrace them. We must be bold in our push for a better future and that absolutely must extend to our health care system.

The 21st century intelligent Medicaid system will have the patient at its center. It will maximize patient choice, be a rapid adopter of new technology, and have incentives for the patients to shop around with regard to both quality and price based on clear, objective

information – the kind of clear and objective information that is readily available for free on ebay, Edmunds.com, Amazon.com, Expedia, etc. The state’s role in the Medicaid sphere will be to stimulate and facilitate the exchange of price and quality information and to create a system for patients where this data is of maximum utility. People on Medicaid are not too stupid to take into account such information when making their health care decisions.

Indeed, when asked in a recent poll if health care consumers have the “right to know cost and quality information from their health care providers,” 93 percent said yes. Only 91 percent agree that “God” should be in the Pledge of Allegiance.

The 21st century system will recognize that Medicaid consists of three distinct population groups with different needs. The first is the healthy poor who make up the vast majority of people on Medicaid, but account for a minority of the bill. This group should be mainstreamed into individually-chosen and owned private health insurance. An ideal emphasis would be on Health Savings Accounts where dollars are owned by the person and can never be taken away. If a low income worker is Medicaid eligible then Medicaid dollars should be available to help that worker buy into the employer’s plan. A worker’s coverage should be seamless. This is particularly important to individuals with chronic conditions who most benefit from continuity of care.

Health Insurance Flexibility and Accountability (HIFA) waivers must be used with this population. Effective use of HIFA waivers will help alleviate the so-called “Medicaid cliff” whereby people who get a job lose their eligibility for Medicaid because of their new income, but do not have employer-based health insurance. This can serve as a powerful deterrent to people moving into the workforce.

The second key population is the blind and disabled. In many cases, individuals with disabilities are eminently capable of participating in the workforce in some way, shape, or form. Medicaid must be a partner in helping to make that happen. The Medicaid “cliff” problem is particularly acute in the disabled community because they are generally far more dependent on Medicaid and typical private health insurance may not cover the range of services they require.

The Cash and Counseling (or Independence Plus) demonstration programs have been particularly effective in the disabled community. The original three Cash and Counseling demonstration projects, in Florida, New Jersey, and Arkansas, have been in existence for over five years now. They are essentially a Health Savings Account for people on Medicaid. Patients can use that money to hire their own personal attendants. The name of the beneficiary appears on the check to make it clear to the provider of services who is the employer. Patients can accumulate unused funds to purchase a larger item related to their health care needs such as a lift chair in their home.

The third distinct population is the elderly. The emphasis should be on active, healthy aging. The latest standards and technologies in home diagnostic equipment, real-time monitoring, and instant assistance when needed can dramatically improve quality of life

and reduce the cost of care. Seniors strongly prefer independence and remaining in their own homes. This happens to be less expensive as well. Enlightened public policy favors seniors staying in their homes and out of institutions in all but the most extreme circumstances such as advanced Alzheimer's.

One example of a successful program for seniors that has taken off in a number of states is Silver Sneakers. Seniors who participate in group exercise programs reap the twin benefits of physical activity and social interaction. The program is responsible for dramatic drops in both depression and medication use. Medical claims for participating members decreased 66 percent and depression dropped over 60 percent. This program is particularly beneficial for older women who live alone.

A 21st century intelligent Medicaid system will know exactly who is in the program, their health status, and the most effective course of treatment. It will have information available to patients regarding the price and quality of providers in their area. Biometric identification technology will be used to create accurate electronic health records of patients to avoid treatment and/or medication errors. Finger imaging or an iris scan will guarantee the patient's identity without that patient being asked for ID or their Medicaid card both of which can be easily lost or forged. An instantly identifiable patient is also far less likely to get multiple unnecessary prescriptions from various pharmacies.

Hurricane Katrina has clearly demonstrated the need for electronic health records. People who were fortunate enough to flee New Orleans with their cars could show up at a Jiffy Lube in Houston they've never been to and within seconds be told by a technician when their car last had its oil changed or tires rotated. But the same person's medical record that contained their vaccination and medication history was likely in paper form and washed away by the flood waters. Paper kills.

Electronic health records, because they cut down on administrative overhead and reduce the likelihood of medical errors, could save \$350 billion over the first ten years across the health care system as a whole. That translates into roughly \$12 billion per year for Medicaid. In Tennessee, every Medicaid beneficiary will have an electronic health record within the year. That state project that for every \$1 spent on the new technology, the state will save \$3-\$4 from reductions in duplicate tests, adverse drug events, and unnecessary patient inspections. That ratio of return on investment will grow to 9-to-1 as the number of providers using the system increases.

Look at ihealthrecord.org which is an interactive personal health records created by the AMA and Medem, a company formed by 47 state medical societies. It provides a standards-based personal health record under the patient's control that is fully HIPAA compliant and allows patient records to be shared among multiple providers. The cost of this is \$25 per month per doctor regardless of their number of patients.

The punishment for misuse of electronic health records must be severe. People are rightly concerned about the privacy of their personal health data. They deserve to have full

confidence that misuse of their information will not be tolerated and that transgressions will be met with severe fines and jail time.

E-prescribing and bar-coding requirements would also cut down on medical errors and save billions. Electronic billing would eliminate paper remittances and could save up to 60 percent. Printing and mailing checks and associated paperwork is more 1905 than 2005.

The 21st century system will have clearly defined objectives and will rigorously measure progress towards their achievement. Former New York City mayor Rudy Giuliani made previously unthinkable strides in combating the crime rate by having a near obsession with measurement. His Compstat compiled crime stats from every region in the city everyday. In 1993 there were up to 10,000 felonies a week and over 2,000 murders a year. Eight years later murders were down 70 percent and overall crime down 65 percent. You will get what you inspect, not what you expect.

“Bureaucracies sometimes resist change because they think large ships can’t be turned around; but even the biggest organization is made up of people, and those individuals either bought into Compstat or were told to find another line of work. Even in a highly unionized workforce like the NYPD, there’s plenty of leverage available.”

One of our members, the National Minority Health Month Foundation can tell you the prevalence of diabetes to the zip code level all across the country. That would be one place to start. Locate those areas, designate a person responsible, and set up objectives for identification of diabetics (because so many don’t even know it) and treatment. The Centers for Disease Control says that one diabetic costs the government \$570,000 over their lifetime. It is in the strong financial interest of the state see that diabetics are identified as early as possible. Diabetes and obesity are as endemic to the information age as tuberculosis was to the industrial age.

The 21st century Medicaid system will focus its resources on the truly poor and not allow richer people with fancy estate lawyers to game the system to pay their nursing home tab. Type: <Medicaid “estate planning” Missouri> into Google and you will find 88,000 hits. There is an entire cottage industry of lawyers that specializes in hiding the assets of people who might not otherwise qualify for Medicaid. The decision you have to make is whether Medicaid should serve as inheritance insurance for richer people or it should be a program targeted exclusively to the low income.

As is true with all states, a small minority of Medicaid beneficiaries (less than 10 percent) runs up a majority of the program’s overall cost. Many of these people are regular, chronic users who suffer from multiple chronic conditions. Disease management holds considerable potential for delivering better care at lower overall cost. It is up to the state to design RFPs and contracts that contain incentives for delivering results. Former California governor Pete Wilson was able to repair a key piece of Interstate 10 back following the 1994 Northridge earthquake two years ahead of schedule by including

strong incentives for execution and severe penalties for failure. What was supposed to take two years and two months took two months and two days. Everyone was better off.

The governor should convene a Medicaid technology fair in early 2006 and gather together the companies that have a demonstrated track record of success with programs that save lives and save money. If you put the call out that Missouri Medicaid is actively seeking transforming solutions, you will be pleasantly surprised at the response. This is something we would be happy to help with.

State Successes

Medicaid is not one program. There are 56 distinct Medicaid programs across the United States in all 50 states, the District of Columbia and the territories. If you know one Medicaid program, you know one Medicaid program. The advantage of this diversity is that states leaders headed down the path of reform have a range of successes and failures to study.

Governor Jeb Bush in Florida has been the most pro-active governor in the country on this topic. He has taken a genuine leadership role in designing a patient-centered system that empowers individuals on Medicaid to choose among competing plans. Under his waiver, provider networks chosen by the patient will be paid a risk-adjusted lump sum that will be used to fund three components: comprehensive care, catastrophic care, and an enhanced benefits package available to compliant patients. Plans will have considerably more authority to tailor benefits to the needs of individuals and set up incentives for meeting various health metrics. Patients who demonstrate success in losing weight, controlling their diabetes, or staying on their drug regimen, for example, will qualify for an enhanced package of benefits. Separate from this waiver request, Florida has made major strides in combating misuse and abuse of prescription drugs by providing thousands of Medicaid doctors with free personal data assistants (PDAs) to track prescriptions.

Governor Mark Sanford in South Carolina is currently in the process of putting together an 1115 waiver that would be a dramatic departure from the status quo. His proposal involves the creation of Personal Health Accounts which beneficiaries would use to pay for their health expenses. Benefit plans approved by the state would then compete for the business of Medicaid beneficiaries. This is a bold attempt to strike at the root of what ails Medicaid – lack of competitive market and perverse incentives that encourage overspending and penalize efficiency. Deposits into the PHA will be made quarterly and unused funds can be used for the purchase of healthcare services at a later time, even up to a year after the person leaves Medicaid.

The Colorado Consumer-Directed Attendant Support (CDAS) program is about to undergo an exponential expansion in 2006. Modeled on the Cash and Counseling demonstration projects, CDAS currently serves 146 Medicaid beneficiaries. Next year the CDAS will be an option for 33,000 people. Beneficiary Linda Story said, “It gives you your life back. Since I have been on CDAS I have more freedom to live my life as every

American should and I'm saving the government money." The first two years of the CDAS pilot program saw average monthly spending come in 21 percent under budget.

In Georgia, Governor Perdue is building his transformation proposal around creating a medical home for everyone on Medicaid. The Center for Health Transformation is also behind our Georgia Project with the active support of the governor. We are working with Bridges to Excellence and major employers across the state to combat diabetes and obesity by leveraging the provider community with pay-for-performance.

The state of Texas has made considerable progress in consolidating the administrative functions of their health departments. Texas also leads the nation in experimenting with biometric identification of patients.

Another highly innovative and successful program that is not in Medicaid but still worth mentioning is the Asheville Project in Asheville, North Carolina. Average overall healthcare costs for diabetics have declined by a third. Cost savings were realized by tapping into the disease management expertise of pharmacists who provided training and counseling of patients to ensure compliance.

Entrepreneurial Public Management

True reform will begin at the top with the creation of a culture that says we will do things differently and our emphasis must be on results, not process. Entrepreneurial incentives and information age system alone will not get the job done. The needed system must also meet the highest standards of accountability, prudence, and honesty. Clear objectives must be established on identification and treatment of diseases. These objectives must then be pursued ruthlessly. It is, after all, people's health and indeed their lives we are talking about. Bureaucratic inertia is no excuse for failing to deliver 21st century medicine.

The governor should convene a task force of volunteer experts who are not employed by the bureaucracy. They could come from a wide range of backgrounds but they would be people with demonstrated track records of success in creating and implementing large scale change. Accomplished individuals such as this would be able to lay out the goals to be achieved, the means by which to achieve them, and identify the sticking points in the system that are hindering success.

Conclusion

The stakes on this issue are extremely high. It is not just money we are talking about but people's lives. The general public in many ways is out front of the politicians on what needs to be done. Americans agree, for example, by a margin of 82 percent to 12 that a co-pay on Medicaid should be required of \$5 to \$10 per physician visit and \$3 to \$5 per prescription drug. By 86 percent to 9 they agree that there should be an annual eligibility

review of everyone on Medicaid to help rid the system of fraud and abuse. By 84 percent to 12, they agree that people seeking treatment should supply proof they are in this country legally before they can achieve Medicaid benefits. 87 percent agree that a trained nurse should be assigned to assist people to better manage chronic conditions. 66 percent of those surveyed would provide discounts or waive co-payments for people on Medicaid who demonstrate healthy behaviors.

Missouri must seek out and implement solidly pro-patient policies. Again, a 21st century intelligent Medicaid system will save lives and save money. The two need not be mutually exclusive. At the Center for Health Transformation we stand ready to help and we very much look forward to working with you into the future on this critical topic.