

Gail R. Wilensky

## improving value in Medicaid

As states continue to struggle with their budgets, controlling spending on Medicaid looms as one of their most difficult challenges. The states are coming to realize that future efforts must focus not just on slowing Medicaid spending, but also on improving the value it delivers.

This is not to suggest that getting the greatest possible value from Medicaid spending is a new idea. With expenditures for Medicaid growing to the point that the program has surpassed education in many states as their highest area of spending, states have long focused on finding ways to slow this growth—and to increase the federal contributions they receive for their Medicaid spending. Improving value has been part of those efforts. Now, however, the states are beginning to see value as a way to limit further financial stresses from Medicaid.

### Some Medicaid Facts

By most estimates, about 68 million people are currently on Medicaid. Of these, 49 million are in Medicaid managed care programs, which exist in some form or other in all but three states.

However, most of these 49 million beneficiaries are among the lowest spenders in Medicaid—the “moms and kids” using acute care services. The heavy users, the elderly and disabled, remain in fee-for-service Medicaid.

For years, the aged and disabled have accounted for a disproportionately large part of Medicaid spending. Today, the situation remains much as it has for decades: Although these people represent only about one-quarter of Medicaid beneficiaries, they account for at least two-thirds of the dollars spent.

In addition, about 9 million people are on both Medicare and Medicaid, and roughly one-third of

these people, called dual eligibles, are disabled and notoriously high-spenders. The average amount spent on each dual eligible exceeds \$20,000 and accounts for almost 40 percent of the Medicaid dollars. Few are in managed or coordinated care programs.

### Increasing Interest in Managing and Coordinating Care

With states under so much fiscal pressure already with Medicaid, it is hardly surprising that they are expressing increased concerns about how they will cope with the large expansions in Medicaid coverage that are scheduled to occur in 2014—even with the increased federal match for Medicaid planned for the early years of the Affordable Care Act. These concerns are spurring states' efforts to find ways to improve the quality of care delivered under the Medicaid program and to constrain spending, particularly for the expensive populations remaining in traditional fee-for-service Medicaid. Any mandatory shift of disabled and dually eligible populations away from the fragmented, uncoordinated care they have received in fee-for-service Medicaid will require permission from the Centers for Medicare & Medicaid Services (CMS). It will also require new performance measures.

The Affordable Care Act has established that performance measures are now required for those who remain in fee-for-service. These measures will become an important equalizer in understanding the relative impacts of managed care and fee-for-service Medicaid on the outcomes of the populations they serve. Medicaid managed care programs, by law, have had to develop performance measures for their populations, although many of the measures used to date have been relevant primarily to the users of acute care

services under age 65, who represent the pre-dominant population in Medicaid managed care.

Improving performance measurements for the fee-for-service populations will remain important as long as a substantial number of expensive users continue to receive that type of care. But developing appropriate measures will be no simple matter. It's challenging enough to develop appropriate process and outcome measures for care of aged and disabled patients in the Medicare managed care population. With the fee-for-service population, this challenge is more intense because, historically, there has been so much less focus on developing performance measures in fee-for-service care.

Useful suggestions on how to begin developing measures for fee-for-service Medicaid are included in a report developed last year for the California Health Care Foundation.<sup>a</sup> The report suggests starting with Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are used by more than 90 percent of U.S. health plans to measure healthcare performance. It recommends then adding a series of measures that are specialized for the dual eligibles or disabled populations. Especially important to include will be measures of behavioral health, which has not been a focus in HEDIS.

### Potential Savings

Because there has been so little application of managed or coordinated care to the most expensive Medicare-Medicaid dual-eligible populations, the potential savings are thought to be quite significant. Kenneth Thorpe, PhD, of Emory University has estimated the potential savings of \$125.5 billion over 10 years (\$80.9 billion from Medicare; \$40 billion from Medicaid) coming mostly from reduced hospitalizations and fewer nursing home readmissions.<sup>b</sup> UnitedHealth Group has estimated a similar amount of savings:

a. Lind, A., Berenson, J., and Highsmith, N., *Performance Measurement in Fee-for-Service Medicaid: Emerging Best Practices*, October 2010.

b. Thorpe, K.E., *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles*, September 2011.

federal savings of about \$100 billion over 10 years with full enrollment in evidenced-based Medicaid managed care.<sup>c</sup>

One of the challenges will be in motivating states to strive to create these savings, because most of the savings will go to the federal government, given that it finances all of Medicare and the majority of Medicaid spending and, therefore, will benefit most from any slow-down in spending. A similar challenge led to development of the idea of accountable care organizations—where physicians who are believed to create most of the potential savings were unable to share in the savings unless they were formally organized with hospitals in a way compliant with Stark regulations and anti-kickback provisions of Medicare. It is an open question whether the federal government will be willing to share some of the savings that it gains from the states' efforts in applying managed care to the disabled or dual eligibles. The answer may depend on how the question is framed—that is, asking the federal government to explore possible “win-win” strategies as opposed to simply asking it to share its savings. The latter approach represents an unpromising strategy.

### Some Appropriate Concerns

The drivers for Medicaid savings are clear. The risks and concerns of moving populations into Medicaid managed care that have not previously been included in managed care are also clear—whether access to care will be reduced and quality and appropriateness of care will be diminished. These issues are also relevant to fee-for-service Medicaid, but in this case, because the financial incentives are so different, the tendency has been to ignore them. Getting good performance and outcome measures for care provided under Medicaid, whether fee-for-service or managed care, will clearly be the best response to these concerns—and for improved care for the Medicaid populations. ●

c. Conversation with Simon Stevens, executive vice president, UnitedHealth Group, September 2011.

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