

# Medicaid HIT Reform and the EMR Diversion

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Widespread adoption of electronic medical record systems in the future is a noble and necessary objective, however it distracts policy makers from enabling true Health Information Technology reform now. While the U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology and others continue to make strides to support EMRs and a national health information network, many in the health sphere confuse the advancement of EMRs with overall HIT reform. As industry pundits debate the potential clinical benefits and cost reductions that EMR systems could deliver, there is too little discussion about how HIT can improve the single largest payer of health care claims—Medicaid. Medicaid continues to consume a growing percentage of states' overall budgets and costs are still rising. Why? Because the current Medicaid system is extremely large and the demand for Medicaid services continues to increase, yet this complex system is riddled with inefficiencies and fails to provide consistently high quality healthcare. These inefficiencies are due to lack of coordination, medical errors, poor communication, incomplete records, rising insurance costs and a myriad of other factors. EMR systems alone will not solve these problems.

The Federal government encourages Medicaid reform, but most states will rely on cost savings mandates like increasing co-pays, making it more difficult to qualify for nursing home care, and discounting drug reimbursements. What States really need is a strategy to break down the silos of the fractured healthcare system. Electronic medical records and cost cutting measures will help, but they are not the only vehicle for Medicaid policy reform. Real Medicaid policy reform will come by leveraging technology to unite Medicaid's redundant and disconnected factions. Medicaid and all its associated agencies and programs can be broken down into three categories: Policy—establishing the overall healthcare goals that determine who is being served, what services they are provided, who will provide them, and how they will be evaluated; Administration—managing the programs, infrastructure and overhead that bring the policy to life and maintain operations, and finally; Healthcare delivery—the care and services dispensed by doctors, disability services providers, hospitals, skilled nursing centers and others who interact with patients. Today, states have comprehensive administrative and claims data that are primarily used to pay claims when they could be used for much more. Medicaid systems are packed with valuable information and patterns about consumption, services, outcomes, treatment regimens, and prescription drugs. Why not empower providers with tools to access patient data and decision support for better preventive and chronic care management? Why not provide enhanced information to enrollees for consumer directed care programs? Each of these is a solid advancement in reform, however, if each of the three main Medicaid categories do not work together to create, manage and evaluate the programs, systematic improvement is impossible. Advancing IT reform alone is not enough—states must take the next step to use the new information effectively, and thus administer the Medicaid program as a system, rather than a disparate collection of programs tied together by a budget authority. For example, we know that less than 20 percent of the Medicaid population consumes more than

70 percent of Medicaid expenditures. This population is characterized by multiple chronic conditions and disabilities. This is also a population that is typically receiving services across the health care spectrum but providers from the aging system, acute care system and mental health system do not have access to patient information outside of their silo. Coordinating care for the most expensive population will lead to higher quality, a reduction in duplicative services, better outcomes and overall lower costs. Even if administrators focus only on this relatively small population, they would address 70 percent of the costs in the Medicaid system. And, in this case, costs would be reduced not through charging more or denying access, but rather by coordinating care and improving outcomes.

Interoperable healthcare IT systems are critical to uniting the three core Medicaid constituencies—they link together policy, administration and healthcare delivery. Once created, this information can be used to increase efficiency and change behaviors that will lead to lower costs, better quality care and more healthy Americans. To achieve this goal, decades-old mainframe Medicaid IT systems must be replaced with systems built on today's standards. Creating EMRs is futile if the system in which they are managed is not improved. Today, Medicaid possesses the rudimentary technology systems and a robust set of data that is continuously updated, yet it is rarely used for anything other than paying claims. This lack of planning and insufficient information sharing means Medicaid systems do an insufficient job managing patient care while valuable information that can help states and providers improve patient outcomes sits stunningly underused in data warehouses.

With relatively minimal effort, administrative, claims, eligibility and other existing data sets can be used to make the patient the unit of analysis, rather than segmented programs. Electronic Medicaid health records can then be

developed and, in nearly real-time, this data can both create a dashboard giving administrators a detailed look at the overall system, while at the same time doctors and hospitals and other providers would have access to patient specific records about diagnosis, previous visits and drugs. What is Medicaid spending the most money on? Who is it spending the most money on? How much money is wasted on duplication? How much money is wasted on non-optimal care settings? What would the impact be if existing care was simply managed better? This data exists today, but not in a way that is shared among Medicaid departments or organized in a meaningful manner. Simply creating EMRs does not solve this problem. For example, with evidence-based data and predictive modeling, providers could devise a strategy to improve the health of 240 Medicaid patients on their caseload with chronic diabetes. They could make informed decisions about treatment plans; actively engaging the patients in their own care. States could even be so bold as to incent physicians for improving the health of these patients. By presenting this information to providers in an easy-to-use Web portal, physicians could more easily identify patients that cost a lot to manage, helping them get a better idea of who their patients are and how they can solve their medical problems. Everybody wins in this scenario: patients receive better care and Medicaid runs more efficiently and more effectively. EMRs play a role, but they are only part of the solution—it is the backend Medicaid Management Information Systems that are critical to developing a successful HIT strategy for Medicaid. EMRs alone will not solve the nation's Medicaid crisis. Medicaid must develop an integrated approach leveraging technology to maximize existing data to make informed decisions about policy, administration and patient care. The dialogue around EMRs is good, but it is the tip of the iceberg—the industry must open a dialogue to look at how MMIS has the potential to link policy, administration and healthcare delivery to reduce costs and improve care. Forward thinking states like Michigan, Maine and Washington have adopted this approach and are emerging as the

standard bearers for the future of Medicaid.

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