Medicaid’s Next Frontier

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Medicaid Lives Through Katrina Every Single DayMedicaid serves 53 million Americans and spends more than $300 billion a year. However, huge portions of the population visit emergency rooms and are treated like they have no medical history—because, in many cases, they do not. There’s no record of medications they take, previous tests administered or other valuable data that

could be applied to provide better, more efficient care.

This problem gained considerable attention following Katrina when the U.S. Department of Health and Human Services developed a Medicaid waiver authority streamlining the eligibility determination process to make decisions in a few days instead of a few weeks. This is minor progress that only occurred because of extreme situations. Medicaid fails to have the same approach on critical, everyday issues that require analysis. But before we can explain what needs to be done, we must have a better understanding of where Medicaid faces the greatest pressure.

In 2003, Medicaid eclipsed Medicare as the largest payer of medical claims in the United States, and it continues to grow. While the program's overall growth is important to understand, it is even more important to understand where the greatest expenses are incurred. According to a study by the Kaiser Commission on Medicaid and the Uninsured, since 2002 the top three factors increasing state Medicaid spending are healthcare costs, enrollment growth and prescription drug costs (Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006, Pub #7392).

Who spends these funds? When most people think of Medicaid, they think about treatment for mothers and children. However, Medicaid has seen a major shift in the population for which it provides care.In reality, less than 25 percent of the Medicaid population spends more than 70 percent of the program's budget. The cost of providing healthcare to a healthy mother or child is roughly $155 per person per month, or a little less than $2, 000 a year. The cost of providing services for the 25 percent who spend more than 70 percent of the Medicaid budget eclipses $4, 000 a month, nearly $50, 000 per person per year. That said, the majority of the Medicaid budget is not treating mothers and children as once commonly believed.

Each of the millions of Medicaid enrollees consumes services

from several different divisions—medical care, mental health, and long-term care. However, Medicaid is not designed in a way that makes it easy for these different divisions to communicate with each other: Every time a patient is seen by a different provider offering services for a different division, providers create new patient record information. This is not only extremely inefficient, but it also fails to leverage existing health data to improve processes, increase efficiencies and, ultimately, provide better care.

Medicaid Revolution Through IT EvolutionSince the beginning of the Medicaid program 40 years ago, the most common reforms for reducing costs and improving efficiency have been: 1) cutting eligibility; 2) cutting reimbursement and/or; 3) cutting benefits. This has never been an effective approach because cost cutting deprives people of care they need. Not a very good approach for an organization whose mission is to focus on the wellbeing of citizens, not just the bottom line.

The fourth and largely overlooked option to empower Medicaid reform is leveraging technology to increase efficiency. Information technology can have a significant impact on Medicaid reform, but it must become a useful tool for the provider community in a way that does not take more effort than it is going to be worth.

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.Components of state Medicaid programs are all expenditures from the same source; however, information is only shared between programs for the purpose of paying bills. States are not thinking about how to improve the utility of their Medicaid IT systems. Why? In order to convince Medicaid

CIOs to implement a more integrated system that treats patients holistically, there must be a change in mindset. This represents a new risk: Paying claims is a necessity, but keeping electronic patient records is optional.

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 create a dashboard giving administrators a detailed look at the system. 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 nonoptimal care settings? What would the impact be if existing care were simply managed better? This data exists, just not in a way that is shared among Medicaid departments or organized in a meaningful manner.

A Medicaid technology evolution can go even further. By incorporating predictive modeling technology, states can turn existing claims paying data into data that tells a story about a patient. But it is not good enough to keep this information within Medicaid walls. Patients, providers and medical institutions need access to this information so they can become part of the solution.

Imagine if states developed Web-based information portals where providers could easily determine who their sickest patients are, by name and disease, not just the total number of them? What if states enabled providers to use predictive modeling to help them understand who their sickest patients will be without intervention? Again, with 25 percent of the Medicaid population consuming 70 percent of the budget, everyone involved could act more efficiently for top to bottom benefits.

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 who 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.

Visionary MMIS and Intermediary StepsState Medicaid programs need to focus on increasing efficiency by maximizing data they already have, reducing duplicative and unnecessary care, and increasing integrated and evidence-based treatment. Sharing information among providers, focusing on care management, leveraging predictive modeling, creating portals to help payers and providers make better decisions—all of these things are key to creating a sustainable Medicaid program.Transforming Medicaid management information systems into more than sophisticated claims payment systems is a long-term goal that has the potential to revolutionize Medicaid reform. However, intermediary steps can be taken; we may be years away from ubiquitous electronic patient records, but the information needed to make these basic changes exists today. Ultimately, it comes down to better communication within Medicaid. Technology is the platform for this change and, until it comes, Medicaid and the Americans it cares for will continue to live through Katrina day after day.