NAMD
National Association of Medicaid Directors

Creating a Climate for Innovation

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Runaway health care cost inflation, often poor health care outcomes, and growing rolls in public health care programs, particularly Medicaid, contribute to fiscal pressures and frustration with our nation's health care system. There is a prevailing desire to reorient the health care system to achieve better care, better health and lower costs. To successfully achieve this vision, Medicaid programs must serve as a platform for innovation and system-wide care improvement.

Medicaid, however, is not structured to meet this need. There are systemic problems with the current federal-state partnership that have been cemented over many years, in part due to a lack of trust in state intent and an unerring commitment to protect the status quo. The federal state partnership is flawed because it focuses on the wrong things. Rather than coordination, health outcomes, program integrity and efficiency—federal rules have a heavy hand in every aspect of Medicaid programs and remain fixed on process measures. The current policies and procedures bog states down in endless, repetitive reporting and change requests and do not prepare states with the tools Medicaid needs to succeed. Further, the culture of Medicaid oversight does not foster innovation—as exemplified by the restrictive way states must pursue demonstrations—and it does not provide a pathway to rapidly diffuse and broadly adopt successful program reforms.

Much of the potential gain from states serving as the laboratories of experimentation has been lost. The transaction costs of innovation in Medicaid have simply been too high and the dissemination of best practices and successful innovations has been too slow. The program and everyone who depends on it are now paying a steep price for these failures. Addressing these challenges will entail new roles for states, the federal government and program stakeholders. In this document, Medicaid directors lay out our vision for a new business relationship between states and the federal government to support a culture of innovation in Medicaid.

Working together states and the Federal government could better position Medicaid for the challenges that lie ahead. The nation's Medicaid Directors have identified numerous

shared goals with our federal partners. Derived from these goals are principles that should be followed in transforming the business practices and culture of the federal – state partnership that is the foundation of the Medicaid program.

Shared Goals

Medicaid directors, like their partners at the federal level, seek a Medicaid program structure that is sustainable and that provides the services that enrollees need and expect. This mutual aim, however, must be met within the highly dynamic context of the US health care system. Spiraling health care costs, the spread of chronic disease, and advancements in expensive medical technologies all create an environment that has spurred public and private entities to seek ways to better manage costs while still providing quality services and consumer supports. In every context, the conversation is turning to innovations in payment structures and delivery systems that will accomplish this goal, and Medicaid must be a player in that policy world to ensure the same outcomes for Medicaid recipients as for other covered populations.

In essence, Medicaid must have the ability to be as nimble in its policy and business practices as other large payers in the health care market place. This is the only way that Medicaid can be assured of achieving the following goals:

a) Good outcomes for consumers/beneficiaries
b) Safety net services that are delivered at the appropriate time in the appropriate setting
c) A fiscally sustainable program for states and the federal government
d) A program that is a leader and driver in improving the health care system

Despite these clearly shared goals, there are barriers to achieving them. Medicaid directors believe it is important to parse out these barriers so that specific solutions to overcome them can be identified and understood by all stakeholders to the Medicaid program. From the NAMD perspective, these are the most critical challenges preventing the program from attaining optimal structures for innovation and sustainability:

- Outdated and rigid business practices that slow innovation and create administrative burden—often at the cost of better and more coordinated care;
- A federal oversight culture focused on bureaucratic, and, at times, counterproductive processes that protect the status quo to the detriment of better care for enrollees and value for the program; and

- An overall approach that stymies the adoption of best practices and slows the translation of new ideas into standard practice.

Principles for Innovation

The following are three overarching principles to retool Medicaid business practices and fundamentally shift the federal-state relationship in ways that can help states and the federal government realize our shared goals for the Medicaid program.

- Support innovation and rapid dissemination of Medicaid practices.
- Prioritize mutually agreed upon outcomes for Medicaid.
- Simplify Medicaid business practices.

These principles also serve as a launch pad for modernizing a broad range of other aspects of the Medicaid program and NAMD will be working to highlight those in the future.

Support innovation and rapid dissemination of Medicaid practices.

In most other sectors of the economy and government, innovations emerge, pilots and experimentation are encouraged, and then regulation is developed to both shape and define practice as information is broadly diffused. However, in Medicaid, innovation is inhibited and rarely moves beyond first experimental steps. Experimentation is a structural exception that requires special permissions or "waivers" of Medicaid rules. Medicaid demonstration and waiver processes are fraught with significant regulatory uncertainty. Rather than focusing on the goals and desired outcomes of a demonstration, states are bogged down in a negotiating process and continuously seeking re-approval of the details of programs. Medicaid is not structured to support rapid review and translation of demonstrations that will allow state of the art models to become standard practice.

Federal policymakers should retool Medicaid's broken demonstration process. Instead, Medicaid directors call on policymakers to adopt new business practices to support a diffusion pipeline for Medicaid innovations that achieve the shared goals. One reasonable way forward is to model the approach of the Centers for Medicare and Medicaid Innovation, and specifically the Medicare and Medicaid Federal Coordinated Care Office, which is working with states to test, and then disseminate successful integrated care models for the dually eligible population. Similarly, Medicaid directors

call for a new business practice to enable states to test and quickly standardize successful models that focus on healthy people, outcomes, and value -- Medicaid's H.O.V. program. At its core, the Medicaid H.O.V. program is about revamping the current demonstration process to provide a more rational path to achieve better care, better health and lower costs.

Medicare and the private sector are making it common practice to standardize and diffuse successfully tested models. This is not possible in the Medicaid program today, yet it is precisely what is needed. The Medicaid H.O.V. program should offer states the option to use simplified checklists, model demonstrations or waivers, and other vehicles to facilitate the path for pre-approved state innovations. Directors would work closely with federal officials on an ongoing basis to recommend innovations for testing through the H.O.V program. As a first step, through Medicaid's H.O.V. program, states could move quickly to implement managed care, system and payment reforms, and service integration changes that are standard practice today. In most cases, these initiatives have consistently provided a pathway to improve access, data sharing, and expand the range of services available to enrollees.

Public and private payers alike have concluded that a weakly coordinated, fee-for-service system is the least effective alternative, and yet this is the model upon which Medicaid's current business model is built. A refashioning of CMS' evaluation and oversight of waivers and SPAs must accompany implementation of the H.O.V. program to reflect our confidence and experience with new delivery and payment models.

Currently, the federal process involves extensive, fragmented oversight reporting requirements that are developed for each individual state request, waiver or SPA. Instead, the Medicaid HOV process would have a clearly demarcated innovation phase that incorporates a rigorous evaluation component. One aspect of this phase would involve states working with federal partners to appropriately stratify measures to allow for sound oversight and troubleshooting.

When innovation concepts successfully achieve stated goals, the evaluation and review would be simplified to focus on core priorities and outcomes. In practice, this means states would adopt standard program-wide measures around expenditures, access, and

outcomes indicators. CMS would quickly review and approve an initial proposal for a change and then rely on the standard measures for oversight.

The Medicaid H.O.V. program would become the standard mechanism to help states adopt the operational models from early adopter states. In this new paradigm, states would test approaches and CMS would focus on rapid diffusion and dissemination. States with successful programs should be supported to rapidly deploy these programs to other appropriate populations, and to fold multiple waivers into a more coherent package for reporting and renewal processing. And additional states adopting a substantially similar program should not have to again enter the testing phase. Instead, they would be accountable for standard program-wide measures. State program directors and the federal government must have mutual trust that this new approach to partnership will not lead to "abuses," but rather to adoption of best practices. Accountability to newly-articulated program metrics focused on health, outcomes, and value will validate this trust.

Prioritize mutually agreed upon outcomes for Medicaid.

Today, state plan amendments and waivers are bogged down by business practices that are focused more on process and less on the goals of achieving better care, better health and lower costs. While designed to serve federal interests and protect beneficiaries, they have come to function as a self-defeating drag on program improvement. Rapid translation of innovation into standard practice would come more readily from federal approval procedures that focus less on process and more on outcomes.

Federal Medicaid business practices must recognize that it is acceptable for states to take different approaches to achieve the same outcomes. In such an environment, if mutually agreed upon outcomes are not achieved, a state would have the autonomy to alter its Medicaid program to achieve the desired outcome. Efforts to consolidate business practices and prioritize outcomes-based reporting would allow considerable progress on the kinds of improvements that can be gained from innovations.

Medicaid Directors believe this is possible, but only in an environment where the federal government and the states can have greater confidence of mutual intent.

Simplify Medicaid business practices.

Over several decades, additional requirements and regulations have been added to the Medicaid program without a thorough evaluation of how to coordinate and prioritize what is already required of states and of the program generally. Multiple layers of regulation now crowd out states' ability to focus on outcomes and force them to come up with complicated "work-arounds" to make their programs consistent with narrow regulatory parameters and ever growing list of procedural and reporting requirements.

As an example of the counterproductive approach, states are required to obtain multiple waivers to operate home and community-based programs that are intended to serve a number of similar populations or provide similar services. Under this construct, states simultaneously conduct and report on HCBS programs that often serve the same individuals. This piecemeal approach to service delivery is counterproductive to achieving priority outcomes and controlling costs.

Federal Medicaid rules should be simplified through consolidation and prioritization with the first step being to re-align the roles of the federal government and states. Together federal and state partners should develop a strategic plan to phase out the federal role for clearance and approval of state plan amendments and waivers. Concurrently, Medicaid would strengthen state accountability for mutually agreed upon measures and outcomes. Utilization of electronic forms of communication should serve to make the changes and individual state programs transparent.

Broadening Support for Medicaid Innovation

State Medicaid directors face more than programmatic hurdles in their race to bend, shape and re-tool their programs. The recommendations laid out in this paper will make it easier to develop and adopt system reforms, but improving the federal oversight and renewal process is not the only challenge that states face in their pursuit of excellence. For many of us, staffing and expertise are in short supply. We also note a critical lack of scientific research identifying best practices and evaluating the impact of program innovation and policy choices.

We have identified in this paper a critical set of improvements that should be made in Medicaid. We look forward to working with Congress, the Administration, and other

stakeholders to address not only the potential barriers to innovation in Medicaid, but the need to encourage, support and inform innovation on a scale equal to Medicaid's critical role as the nation's health care safety net.

The National Association for Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD provides a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future.

NAMD Contacts:

Andrea Maresca, Director of Federal Policy and Strategy, andrea.maresca@namd-us.org
Kathleen Nolan, Director of State Policy and Practice, Kathleen.nolan@namd-us.org