



**Synthesis of Stakeholder Roundtable Discussion on
Alternatives to Reform: “Envisioning a Better Medicaid”**
September 2008

A. Overall Approach to the System

1. All consumers have a true medical home.
2. Primary care decision-making is balanced with consumer needs and preferences.
3. An emphasis is placed on prevention and wellness.
4. Timely and appropriate access to follow up care is assured.

B. Benefits and Services

1. Establish a minimum comprehensive defined benefit package, including the current Medicaid Preferred Drug List as the defined minimum pharmacy benefit.
2. Permit deviation from the defined benefit (amount, scope or duration) only if it is the result of a joint consumer-physician decision. For persons with special needs, that may need to include a case manager.
3. Encourage supplemental benefits and services to be offered above and beyond the minimum.
4. Allow caps on benefits to be flexible; eliminate them altogether when feasible. A variation on this theme would be the establishment of a tiered system of benefit caps, to include: 1) core benefits, particularly primary care visits, which would not be limited, and 2) additional benefits, which would be divided into the following tiers: suggested, medically recommended and non-medically recommended.
5. Allow referrals to specialty care within the provider network without requiring prior authorization.
6. Allow direct access to specialty care for certain diagnoses (e.g., HIV, pregnancy, M.S.).
7. Implement meaningful disease management and wellness incentives (these exist theoretically now, but are not utilized).
8. Recognize that there is a group of Medicaid consumers, particularly those with severe impairments for which Fee-for-Service Medicaid serves a necessary and cost-effective purpose.

C. System Coordination

1. From the provider perspective, the system is coordinated. From the consumer perspective, services are linked.
2. Providers have information about and the ability to work in conjunction with other providers through a provider network database, thereby attending to a multiplicity of needs in coordinated fashion.
3. Primary care is linked with other needed services, particularly through the use of electronic medical records and other appropriate sharing of medical information.
4. The care coordination process initiated at the time the consumer enters the system.
5. The care coordination process integrates medical and behavioral health care treatment plans.
6. The care coordination process includes a mechanism for identifying and attending to psychosocial needs.

D. Choice

1. Ensure the availability of meaningful but manageable choice (vs. selecting least harmful among inadequate options).
2. Impose any limits on choice only if remaining options provide all configurations of needed services, and consumers can still truly “vote with their feet.”
3. Accommodate changing medical needs over time by providing more frequent opportunities to change plans.
4. Require clear and effective outreach as well as dissemination of information needed for meaningfully informed choice.
5. Meaningfully educate consumers to make informed choice. Such educational efforts must have sufficient depth and be appropriately targeted. Efforts to educate and empower must be even more intensive for persons with special needs.

E. Transparency & Accountability

1. Require adherence to national standards (or otherwise define specific measures based on already available demographic, geographic and health data) vs. using cookie-cutter approach. Formulate and implement strategies to ensure that such standards are met.
2. Engage in population-specific planning for consumers with special needs.
3. Mandate that a minimum of 80-90% of plan spending be for direct care, using a carefully defined concept of “direct care”.
4. Establish and maintain an information management structure necessary to allow for rigorous performance measurement and evaluation.
5. Issue a report card with aggregated performance data, identifying and publicizing providers and plans that serve consumers well
6. Ensure ready on-line access to plan formularies, provider networks and other important plan information that consumers need regularly.

F. Rights and Recourses (“Leveling the Playing Field”)

1. Develop and implement a concrete plan to educate consumers about all of their options and rights.
2. Establish and promote the use of intermediaries such as a Medicaid managed care ombudsman and peer networks.
3. Institute the equivalent of a Medicaid “lemon law” and other penalties for consumer-unfriendly practices.
4. Initiate enhanced enforcement of consumer and civil rights protections as they relate to Medicaid.
5. Establish a clear, open and expedient appeals process.
6. Provide more opportunities for consumers to obtain second opinions.

G. Research & Evaluation

1. Establish and maintain a medical information management system that allows for:
 - a. Collection of baseline data and retrofitting of historical data to allow apples-to-apples comparisons of the Medicaid system as it evolves to its predecessors.
 - b. Systematic measurement and collection of data necessary to formulate big picture evaluation (e.g., cost shifting, denials and delays of medically necessary care).
 - c. Implementation of a data-driven system of accountability.
2. Commission an ongoing evaluation to be conducted by an independent (i.e., not otherwise directly dependent on State funding) entity.
3. Conduct a cost-benefit analysis of shifting to a true “medical home” along with meaningful primary care case management vs. remaining with and expanding the Reform Pilot.
4. Measure and factor in cost shifting onto outside traditional Medicaid system into actuarial study,
5. Survey consumers about their experiences with plans and providers, and incorporate that information into the evaluation process.

H. Incentives

1. Provide financial incentives to promote system goals and improve outcomes. Such incentives could include, but are not limited to:
 - a. Incentives to primary care providers for encouraging wellness programs.
 - b. Incentives to plans for fixing problems and delays in claims processing.
 - c. Incentives for participation generally, especially for specialists.
 - d. Incentives for providers based on performance/outcomes.
2. Increase reimbursement rates for providers in order to avert provider flight and to prevent the permanent relegation of Medicaid consumers to a lower tier of the health care system.
3. Structure incentives to be consumer-focused, not plan-focused.

I. Behavioral Health

1. Emphasize training of primary care providers to recognize and address mental health problems.
2. Better coordinate care between/develop protocols for transition between CSUs, hospital and jail .
3. Increase pharmacy benefit to the extent necessary to divert from hospital or jail.