

Testimony of Alan Weil Before the District of Columbia Department of Health Regarding the Healthy People 2010 Draft Biannual Implementation Plan (2003-2004) for the District of Columbia

Alan Weil

The views expressed in this testimony are those of the author and do not necessarily reflect the views of the trustees and employees of the Urban Institute.

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Good morning. Thank you for the opportunity to testify today on the draft D.C. Healthy People 2010 Biennial Implementation Plan for 2003-2004. My name is Alan Weil. I am a center director at the Urban Institute, a nonpartisan, nonprofit research organization located here in the District. I have written and spoken extensively regarding Medicaid and health insurance coverage for low-income people. Before coming to the Urban Institute I was the executive director of the Colorado Department of Health Care Policy and Financing, which is the cabinet agency that administers the Medicaid program. I currently serve as a member of the District's Medical Care Advisory Committee, which advises the deputy director of the Department of Health on issues related to Medicaid. My testimony today draws from these experiences but should not be interpreted as representing the views of any organization.

I was asked to address the section of the implementation draft on health care financing, although I note that the two implementation goals in this portion of the plan have more to do with access and data than they do with financing per se.

Goal 8-3

Goal 8-3 calls for a comprehensive data reporting system as an update to the aging Medicaid Management Information System. This is certainly a worthy goal—one that reflects the evolving role of the Medicaid program. Nationwide, the Medicaid program has shifted from the complex but relatively passive task of processing medical claims to become a more sophisticated purchaser of health care services on behalf of the enrolled population.

The first phase of this shift was the use of managed care. Medicaid agencies around the country essentially outsourced the job of improving health care delivery by contracting with managed care organizations that had the necessary infrastructure to monitor and modify the utilization of the covered population.

Over the last five years, the limitations of the managed care contracting model have become clear. First, because of the payment methods used, managed care organizations have an incentive to deliver too little care—the opposite of the traditional fee-for-service system in which providers have an incentive to deliver too much care. Thus, oversight of managed care organizations is critical if Medicaid enrollees are to be ensured access to necessary services. Some of this oversight takes place through monitoring aggregate measures, such as rates of immunizations and preventive screens. But a data system that reaches down to the individual claim level is also necessary, because aggregate data miss certain important aspects of access and quality.

The second limitation of the managed care model is its limited applicability for the populations that account for the largest share of the costs in every state's Medicaid program: the elderly and people with disabilities. In the District, as elsewhere, managed care enrollment focuses on children and their parents, who account for the majority of Medicaid enrollees but a minority of costs. Traditional managed care systems simply do not work for the more complex needs of the elderly and people with disabilities. While some models have been developed for these groups around the country, most are still in their infancy, their share of enrollment remains quite small, and the need for external quality monitoring is even greater than for the TANF and poverty-related populations.

Thus, the second phase of Medicaid's shift from claims payer to care manager involves more direct analysis of utilization patterns for Medicaid enrollees. In order to do this, the Medicaid agency must have a reliable source of claims-level data to monitor the program and improve the quality of care that the program's enrollees receive. However, having the data is not enough. Looking around the country a few additional lessons are clear.

First, the data warehouse, as these systems are often called, should also contain data from related systems. In the District, the obvious other source of data is the Alliance. The relationship between services delivered

through the Alliance and through Medicaid is a critical one to monitor for cost and quality reasons.

Second, a data warehouse is only useful if people actually analyze the data. Issues of data quality, comparability, and accessibility are legion in health care claims data. A commitment to a data warehouse must be combined with a commitment to data quality, a well-thought-through analysis plan, and a commitment to appropriate sharing of data, while fully guarding patient confidentiality, so that external analysts can leverage the limited resources of the District.

Third, a data warehouse is only useful if the results of analysis from the data feed back into the policy process. If we are to achieve the goals of Healthy People 2010, and not just adopt processes that are loosely consistent with those goals, we need to be ready to match public policy with what we learn from our analysis. This is particularly important given the complex medical and social needs of the Medicaid population.

Finally, I would note that the stakes are particularly high on this activity given the current political environment regarding Medicaid. Last year the Bush administration proposed converting the Medicaid program into a block grant—although they avoided using that specific term. With state budgets recovering only slowly from the rapid decline in revenues experienced during the most recent economic downturn, governors and state legislators are desperate for relief from the upward spending pressure Medicaid consistently imposes. In that desperation, ideas like block grants become more appealing for the short-term relief they offer, even if they may bring with them serious negative long-term consequences for states and the people Medicaid serves.

Regardless of the outcome of the block grant debate, fiscal pressure related to the Medicaid program is certain to remain high well into the future. Close analysis of utilization data can provide one tool for improving the health care delivery system in a manner that improves outcomes for patients while also holding down system costs.

Goal 8-7

Goal 8-7 calls for access to comprehensive behavioral health services for all Medicaid-eligible persons. This is certainly a worthy goal, but the framing of the objective derived from that goal points out the weaknesses of the current system. The stated objective and recommended action is all about process: state plan amendments, billing systems, and the like. Missing are any outcome measures that would give the residents of the District and the affected Medicaid enrollees any confidence that the necessary services are being delivered.

I acknowledge that the first step in achieving the goal of access to comprehensive behavioral health services is to develop certain administrative systems. Certainly, the District should pursue this action. But I encourage the District to aim higher and include a substantial monitoring component to ensure that the systems that are developed achieve their intended outcomes.

Concluding Remarks

I would like to close with a few broader comments about the goals and objectives included, and not included, in the draft implementation plan.

When reading the national Healthy People 2010 goals, the very first objective is to increase the proportion of people with health insurance, and the goal is set at 100 percent. In addition, earlier this week the Institute of Medicine issued a report calling for universal health insurance coverage by the year 2010. I acknowledge that the District—like the 50 states—needs substantial federal assistance in achieving this goal. At the same time, I note that, while a number of insurance-related objectives appear in the District's Healthy People 2010 plan, progress toward them is not included in the draft implementation plan. If the District is to achieve these important goals, action on them cannot wait until the end of the decade.

Today, given fiscal pressure and rising health care costs, many people are worried about preserving existing insurance coverage before they even consider expanding that coverage. Medicaid has come under attack as an expensive program and one that, due to low reimbursement rates and complex administrative rules, fails to provide access to necessary health care services. I want to assure you that the national data paint a very different picture. While Medicaid is certainly expensive, that is primarily due to the complex health care needs of the population it serves. Colleagues of mine at the Urban Institute have concluded that Medicaid actually costs less than private insurance coverage when comparing populations with similar health care needs. In addition, while low payment rates are an impediment to access, other colleagues of mine have demonstrated that Medicaid provides equal and in some instances better access to services than private insurance, again when similar populations are considered. Lacking the data, I cannot say whether these precise results would hold in the District, but we do know that preserving, and when possible expanding, Medicaid coverage is an effective and efficient investment in coverage and access.

District residents face many health care challenges. The two health care financing goals included in the draft implementation plan are important ones, but certainly not the only ones. I urge the Department of Health and other relevant agencies to pursue these goals and to go further in the interest of the health of the residents of the District.

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- Alan Weil

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