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STRENGTHENING **MEDICAID**

Increasing the Medicaid Program's Efficiency and Effectiveness: The Role of Medicaid Program Management

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Overview

Effective and efficient management of the Medicaid program is essential. Managing the Medicaid program well ensures that beneficiaries get the health and long-term care services they need, providers offer high quality care in a system that operates efficiently, and public resources are spent effectively. This paper proposes four discrete strategies to improve and streamline management of different elements of the Medicaid program to help achieve key program goals. The locus for action on some of these strategies is at the state level; in other cases, federal action or involvement is needed.[1]

Although program management is vital to making sure that Medicaid serves the low-income population effectively, there are few proposals to help states and the federal government improve the way in which Medicaid is managed. States have day-to-day responsibility for managing their Medicaid programs, with the federal government providing guidance, setting rules and sharing responsibility for administering some elements of the program. With state budgets strained, it can be challenging for states to make needed up-front management investments that are cost-efficient in the long run. The federal government, with its greater resources and interest in seeing effective practices spread across states, can help support states' efforts.

Making Upgraded Eligibility Systems a Key Part of Efforts to Improve Eligibility Policy

A number of states are improving the processes and policies they use to determine eligibility. Revamping the information technology systems states use to determine eligibility and enroll beneficiaries in Medicaid and CHIP is a key part of these efforts. Many states have been working with eligibility systems that are outdated and were developed in a much earlier era of more rigid computer design and programming. In some cases, states have also worked with multiple systems to meet the needs of different programmatic components, programs or agencies, and these systems cannot communicate with each other easily. Retooling or revamping eligibility systems can help states get eligible people the coverage they need and manage the Medicaid

program more efficiently. Specifically, improved eligibility processes and systems can:

- Help increase enrollment rates among people who are eligible for Medicaid and CHIP by reducing administrative barriers (such as complicated application forms or lost paperwork). Improved, and automated, eligibility processes and systems can also enroll eligible people more quickly, providing them with more timely access to needed services and giving providers a higher level of assurance that they will be paid for care they provide to people who are applying for coverage.[2]

- Improve the accuracy of eligibility determinations, reduce errors, and help ensure program integrity.[3]

- Coordinate eligibility with other system components (such as billing), and across separate but related state programs to eliminate multiple submissions of data.

- Make sure Medicaid has the flexibility to keep up with state and federal eligibility policy changes through simple system changes, instead of having to revamp the whole eligibility system.

- Increase staff productivity, freeing up administrative dollars for reinvestment in program management or services.

Online applications, automated collection and storage of client data and documentation, electronic verification of eligibility, and automated renewal processes can ease administrative burdens for both states and beneficiaries. Significant new eligibility improvement initiatives that focus on information technology (IT) systems upgrades are underway in a number of states: [4]

Pennsylvania's COMPASS system allows families to apply for or renew existing coverage online using electronic signatures for several different programs, including Medicaid and CHIP. COMPASS also coordinates and maintains eligibility information across programs to facilitate enrollment and renewal of coverage, eliminating the need for families to submit information or documentation more than once.

Florida substantially revamped its enrollment processes to employ a highly automated application and redetermination system (ACCESS Florida) that allows consumers to submit online applications. Florida also expanded the use of call centers and community partner assistance. In Florida, eligibility IT improvements along with simplified eligibility policies and reliance on community sites enabled the state to improve customer service and reduce its eligibility staff.

Massachusetts created a "Virtual Gateway" system that creates one-stop shopping for people to apply for Medicaid or other health coverage programs in the state. Applicants can submit paper applications electronically or apply through an eligibility worker or at hospitals and community health centers where applica-

tions are submitted and managed electronically. According to the state, staff productivity has increased and the eligibility error rate has declined since the system was implemented. People in Massachusetts can also apply for child care and the Food Stamp Program through the Virtual Gateway.

Louisiana has revamped its eligibility processes and systems. Applicants can apply through different entry points, with community organizations providing outreach and assistance. State workers scan or enter information from paper applications electronically to create an electronic record that all eligibility workers at all locations can access. In addition, Louisiana employs a process that uses information in varying databases to automatically renew Medicaid and CHIP coverage.

California uses a web-based program, One-E-App, to help families apply, using community assistors, for Medicaid and CHIP, and other programs, through an interactive Internet application that minimizes errors. The One-E-App process makes real-time preliminary eligibility determinations, electronically sends applications to appropriate agencies, and simplifies eligibility renewals.[5]

New York has developed an Internet application, for use by health providers that automatically enrolls in Medicaid infants born to mothers who are Medicaid beneficiaries. States like **Utah** and **Washington** are electronically collecting or verifying data from government agencies to help make accurate and timely eligibility determinations.

States' eligibility IT improvements typically work in conjunction with policy changes, such as creating a health care "front door" through which people apply for Medicaid coverage, increasing use of application assistance and sites at which people can apply, increasing eligibility worker training, and implementing performance measurements. Together, these changes have helped improve the quality and consistency of eligibility decisions. They have also helped states reduce their reliance on eligibility workers even as caseloads increased.[6] Although the upfront investment in information technology systems can be substantial, these investments, along with necessary policy changes and business practices, can produce significant state and federal cost savings through improved accuracy and productivity.[7] For example, Florida estimates that it saves more than $80 million a year by using the ACCESS Florida system.[8]

Recommendations:

Increase management attention to the operation and design of eligibility systems.

Upgraded IT systems can be a key component of efforts to enroll eligible but unenrolled individuals, as well as an investment in improved productivity, customer service and accuracy. To be effective, new IT systems should support broader policy changes and process improvements that are designed to improve outcomes.

Increase federal financial support to states for the costs of developing and maintaining new systems.

Currently, states' investments in eligibility systems are matched at the standard 50 percent matching rate that applies to Medicaid administrative costs. Congress could act to provide enhanced match for eligibility systems, awarded based on a system meeting key criteria designed to ensure that it makes timely, accurate eligibility determinations and redeterminations. This would support federal and state efforts to reduce eligibility errors under the Payment Error Rate Measurement (PERM) project. States currently receive an enhanced Medicaid match for investments to develop and operate data retrieval and billing systems.[9]

Maintaining and Encouraging State Advances in Managing Medicaid for Improved Health Care Value

Many states have been early adopters of some of the approaches to providing "value-driven health care" that are now being intensively discussed at the federal level and by private insurers. For example, the Centers for Medicare and Medicaid Services (CMS) reported last year that more than 35 states already have significant information technology and/or quality strategies under way in Medicaid or CHIP.[10] Similarly, a recent national study found that more than half of all states already operate pay-for-performance programs, in which physicians and other providers are compensated for achieving a specified level of quality performance or improvement, and many other states are moving forward with similar programs.[11] Many states have also led efforts to manage high-cost cases, increase use of cost-effective prescription drugs, and use new technologies like e-prescribing to reduce errors and improve outcomes. While states have made these investments on their own, resource constraints can inhibit some states from moving forward with key program improvements. In addition, evaluations of new approaches are needed, such as evaluating the impact of pay-for-performance programs on beneficiaries and providers.[12] Successful improvements need to be spread across states and tailored to each state's unique needs.

Recommendations:

FEDERAL

Actively promote cross-state learning and cross-state fertilization of approaches to improving program management.

Many states are working to improve management of their own Medicaid programs. The federal government could provide funding to enable states to evaluate new management approaches and assist in dissemination of best practice information across states. In particular, CMS could sponsor forums, on its own or in partnership with expert convening organizations, where states would have an opportunity to learn about improvements and discuss how to tailor them to their states' own unique needs and circumstances.

FEDERAL

Continue the use of the federal Medicaid Transformation Grants to support key state program management advances.

Many states are using the Medicaid Transformation Grants that Congress created in 2005 to undertake new efforts to improve management of the Medicaid program in a number of key areas. In particular, states have focused on opportunities to use technology to drive improved outcomes. For example, some states have used these grants to employ electronic health records in Medicaid, improve neonatal health outcomes, initiate e-prescribing programs, and make faster and more accurate eligibility determinations.[13] Congressional action to fund these grants beyond fiscal year 2008 could help states continue to develop program management improvements. It would also be helpful for CMS to report on the impact of these grants to help promising practices spread to other states.

FEDERAL

Ensure Medicaid is fully integrated into national discussions on health care, such as current discussions to improve value-based purchasing.

Medicaid is a major purchaser of health care in the nation, accounting for roughly one out of every six health care dollars spent in the U.S. Yet the Medicaid program is sometimes not fully integrated into national discussions that are aimed at improving the health care system. For example, the Department of Health and Human Services (HHS) has undertaken significant effort to improve value in the health care system by improving quality, expanding use of information technology, and increasing use of incentives that promote high quality and efficient health care.[14] While CMS has recently encouraged states to participate in efforts to promote value in health care, most of the federal attention so far has been focused on Medicare and private insurers.

Additional efforts should be made to ensure that Medicaid is fully represented in national discussions of improving value in health care. The Medicaid program is the nation's largest health plan in terms of covered lives. Medicaid also provides coverage to large numbers of people with complex, high cost conditions. As such, the program can be a powerful ally and catalyst for system change. Federal officials, state officials, and key program stakeholders should be adequately represented in developing national strategies to improve value in

health care. This will ensure, for example, that the experience of states that have already undertaken value-driven purchasing efforts can be used to help states and other payers that have not yet launched such efforts to consider the best approaches for doing so. For example, Medicaid directors who have run pay-for- performance programs have identified key concerns from these experiences, including the potential impact on provider participation and maintaining access for beneficiaries with complex health needs.[15] These experiences and lessons learned should be integrated into national, cross-insurer discussions on pay-for-performance.

Hawaii's Electronic Health Record and Information Exchange to Improve Primary and Preventive Care for Children in Medicaid

With the support of a Medicaid Transformation Grant, the state of Hawaii is developing an electronic health record (EHR) and information exchange to enable the state and providers to monitor and manage the rate at which children receive primary care and preventive services that are required under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

The EHR will be a comprehensive data source on the provision of EPSDT services and will include data from state claims payment systems, EPSDT reporting forms, managed care encounter data, and data that providers enter into the system directly. Providers and health plans will be able to access the EHR through a web portal to identify children who are due for preventive well-child visits and immunizations. They can also use the system to communicate with each other, which is critical because many children are served by multiple providers. The EHR system will also generate reports that providers can use to manage quality and compare their performance to statewide averages.

The state expects that the system will enable it to establish baseline measurements of provider EPSDT compliance, improve care coordination among providers, minimize potential duplication of services, and work with individual providers to increase the rate of EPSDT compliance. Eventually, the state will also develop EHRs for seniors and people with disabilities who are transitioning to managed care to help ensure that their care is appropriately coordinated and determine which beneficiaries could benefit from care management strategies.

Source: Application for Medicaid Transformation Grant submitted by State of Hawaii Department of Human Services for Hawaii Enhanced Electronic Health Record and Information Exchange, accessed http://www.cms.hhs.gov/MedicaidTransGrants/ on September 8, 2008, and personal communication between Martha Heberlein and Randy Chau, Department of Human Services, State of Hawaii, March 17, 2008.

Improving Care Management and Improving Quality for Seniors and People with Disabilities in order to Facilitate Data Sharing across Medicare and Medicaid

Care for low-income seniors and people with disabilities who qualify for both Medicare and Medicaid (the "dual eligibles") is split between the two programs. Medicare covers most acute care and prescription drugs for these beneficiaries. Medicaid generally finances long term care and pays Medicare premium and cost sharing amounts. Spending on the dually eligible population accounts for over 40 percent of total Medicaid spending across the country.

Recently states have intensified and expanded efforts to manage care for many of the high-cost, chronically ill populations Medicaid serves, and are working actively to improve quality for these and other populations. Care management for the dual eligibles is a potentially promising way to both improve quality and manage costs, but these efforts are hampered by difficulties states have obtaining timely and efficient access to Medicare claims data for the dual eligibles. When data sharing is available, the process for obtaining data is onerous and can make available data difficult for states to use effectively. Although Part D claims data has recently been made available to states, concerns have been raised that the lack of timeliness of this data makes it difficult to use for care management. This lack of transparency across the two programs is a roadblock to state efforts to manage the care of people who are dually eligible, who are some of the highest cost populations Medicaid (and Medicare) serves.

Recommendations:

FEDERAL

Share timely claims data for dual eligibles between CMS and the states in order to support care management strategies across payers.

This would enable states to improve care management programs and measure the extent to which these programs succeed in reducing unnecessary care and improve outcomes for beneficiaries. Sharing claims information between Medicare, private insurers, and in some cases, state Medicaid programs is occurring to a limited extent through CMS's Better Quality Information for Medicare Beneficiaries Project.[16] In addition, information will be shared between Medicare and Medicaid in all 50 states for program integrity purposes through CMS's Medicare/Medicaid Claims Data Match Program (the Medi-Medi program). CMS should build on these existing data sharing efforts to allow claims data to be shared in ways that facilitate effective care management and quality improvement. Timeliness and quality of any Medicare/Medicaid data that is shared will be critical to the success of efforts to use these data for care management.

Improve the Federal/State Partnership on Efforts to Ensure Program Integrity

Additional efforts to ensure program integrity within Medicaid could help ensure that limited public funds are maximized to provide health and long-term care to low-income people. Studies by the Government Accountability Office (GAO) have suggested that efforts to ensure program integrity could be increased, and other studies have noted that, where program integrity risks arise in Medicaid, they are concentrated in actions of some drug manufacturers, providers, managed care organizations, and long-term care providers.[17] Some have also noted that Medicaid program integrity efforts can support critical program goals such as maintaining and improving provider participation, ensuring that eligible people enroll in the program, and ensuring access to care. CMS's new Medicaid Integrity Program is dedicating substantial new resources to ensuring program integrity in Medicaid.[18] States like New York are developing program integrity efforts that focus on improving provider compliance.[19]

Recommendations:

Develop models for measuring and achieving cost avoidance.

The most effective way of ensuring program integrity is to prevent an inappropriate payment from occurring. It is at present difficult to measure the impact of efforts to prevent or minimize program integrity risks, and these initiatives often receive less public attention than higher profile fraud and abuse enforcement actions. CMS is developing performance measures for state program integrity efforts, and measures of cost avoidance could be developed as one such measure of state success. These measures would focus on the effectiveness of state policies and program management to achieve value by avoiding unnecessary payments. Alternatively, states could develop and pilot some measures on their own as state-specific measures of the impact of efforts to avoid unnecessary costs. These measurements could later be used to develop model policy and management approaches for other states to consider adopting.

Improve state provider enrollment practices.

State efforts to promote appropriate enrollment of providers vary.[20] States that do not currently have them could adopt practices like probationary enrollment, improved screening, surety bond requirements, and on-site inspections of some providers. A number of states are undertaking web-based enrollment and certification of providers, and as they do so efforts should be made to ensure that these new programs support program integrity goals.[21] CMS is developing a provider enrollment system for Medicaid and Medicare.[22] Efforts to strengthen provider enrollment practices need to support both program integrity goals and timely and efficient contracting with providers. These management reform efforts could help prevent unscrupulous providers from participating without unnecessarily burdening honest providers.

STATE

Improve a state's ability to prosecute cases of fraud and abuse, and dedicate recoveries to the state's Medicaid program.

The 2005 Deficit Reduction Act allows states with their own versions of the False Claims Act to keep a larger share of recoveries from fraud and abuse cases than states that do not. False Claims Act laws allow states to address and deter instances of significant fraud and abuse against public programs, including Medicaid.[23] States enacting a False Claims Act should dedicate recoveries from Medicaid related false claims cases to the Medicaid program to ensure that dollars wrongly taken from the Medicaid program are returned to it, preserving limited state dollars for health coverage. States could dedicate these funds to outreach, eligibility simplifications, and/or improvements in program administration (including IT upgrades and additional program integrity activities).

FEDERAL

Ensure that federal repayment policies encourage states to identify any overpayments.

Currently the federal government requires that, if a state identifies an overpayment to a provider, the state must repay the federal government within 60 days.[24] Because it can take longer than 60 days for a state to collect any overpayment—and the amount that is ultimately collected may be lower than the amount that is originally identified—states are often required to repay the federal share long before the state actually collects any overpayment. Requiring federal repayment before overpayments are identified can discourage states from identifying overpayments. Asking states to repay the federal share of fraud and abuse cases once overpayments are actually recovered would remove this disincentive.[25] It could also increase recoveries for both states and the federal government as well as improve the sense of partnership between federal and state agencies in addressing program integrity.

Editor's Note

Since this paper was written, two new laws with significant Medicaid provisions were enacted in February 2009: the Child Health Insurance Program Reauthorization Act (P.L. 111-3) and the American Recovery and Reinvestment Act (P.L. 111-5). Some of the provisions of these new laws pertain to topics discussed in this paper. The ARRA, for example, includes significant new funding for health information technology efforts. The child health bill includes a new Express Lane option for states to streamline eligibility procedures, requires the Department of Health and Human Services to develop a model electronic health record, and clarifies that electronic signatures are permissible for Medicaid and CHIP. For more information on the CHIP reauthorization law please see the "Children's Health Insurance Program Reauthorization Act of 2009: An Overview "and Summary available on the Georgetown Center for Children and Families website at ccf.georgetown.edu. For more information on ARRA, see "American Reinvestment and Recovery Act: Medicaid and Health Care Provisions" by the Kaiser Commission on Medicaid and the Uninsured, www.kff.org.

Center for Health Care Strategies provides technical assistance for state quality improvement initiatives, including developing integrated care models for dual eligible beneficiaries. Its Medicaid Best Buys series identifies programs with the potential to improve quality and control costs for high-risk beneficiaries. http://www.chcs.org

Centers for Medicare and Medicaid Services: Medicaid Transformation Grants web site provides an overview of the grants, as well as descriptions of the 35 state programs that have been awarded grants since January 2007. The web site also provides guidance for grantees. http://www.cms.hhs.gov/medicaidtransgrants

The Commonwealth Fund produces research that focuses on improving health care practice and policy, including publications that provide information on quality and efficiency improvement measures in states, such as pay-for-performance and auto-enrollment. http://www.commonwealthfund.org

Henry J. Kaiser Commission on Medicaid and the Uninsured and **The Children's Partnership** released three reports, **Emerging Health Information Technology for Children in Medicaid and CHIP Programs** (November 2008), **Harnessing Technology to Improve Medicaid and CHIP Enrollment and Retention Rates** (May 2007), and **Opening Doorways to Health Care for Children** (April 2006). The reports provide suggestions on creating enrollment doorways and enhancing technology to make enrollment and renewal timely and more responsive to family needs. http://www.kff.org and http://www.childrenspartnership.org

National Academy for State Health Policy has resources on cost-containment and value purchasing, as well as quality and patient safety. Its Medicaid Resource Center offers additional information, tools, and publications. http://www.nashp.org

National Association of State Medicaid Directors has information on state Medicaid programs, state efforts to promote mental health and oral health, as well as information on health information technology and provider enrollment practices. http://www.nasmd.org

National Governors Association Center for Best Practices has resources spotlighting innovative state practices, including **Accelerating Progress: Using Health Information Technology** and **Electronic Health Information Exchange to Improve Care** (September 2008). The report details what states can do to advance the adoption of health IT. It also highlights some of the efforts currently underway at both the federal and state levels. http://www.nga.org

ENDNOTES

[1] Unless otherwise noted, legislation is not needed to undertake the federal actions identified in this paper.

[2] B. Morrow and D. Horner, "Harnessing Technology to Improve Medicaid and CHIP Enrollment and Retention Practices," Kaiser Commission on Medicaid and the Uninsured (July 2007), available at http://www.kff.org/medicaid/7647.cfm.

[3] B. Edwards, V. Smith and G. Moody, "Reforming New York's Eligibility Processes: Lessons from Other States," Medicaid Institute at the United Hospital Fund (July 11, 2008).

[4] Unless otherwise noted, the state examples in this section rely on information in Morrow and Horner 2007 or Edwards et al. July 2008.

[5] op. cit. (2) and http://www.onneeapp.org, accessed on February 28, 2008.

[6] op. cit. (3).

[7] Moreover, the recent investment by CMS and states in developing a new IT framework through the Medicaid Information Technology Architecture (MITA) will help to lay the groundwork for additional and substantial new improvements in IT, both in the area of eligibility and other systems. See R. Friedman, "Medicaid Information Technology Architecture: An Overview," *Health Care Financing Review* (Winter 2006-2007).

[8] op. cit. (2).

[9] 42 CFR 433.11(c).

[10] Letter on Value-Driven Health Care (VHC)/Medicaid Quality Improvement Program (MQIP) from Dennis Smith, Director, Center on Medicaid and State Operations, to State Medicaid Directors, April 25, 2007, SMD #07-005, available at http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1198773&intNumPerPage=10.

[11] K. Kuhmerker and T. Hartman, "Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs," The Commonwealth Fund (April 2007), available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=472891.

[12] L. Simpson, G. Fairbrother, and J. Schuchter, "Moving Forward with Quality: State and Federal Approaches to Measure, Manage, and Improve Quality in the Medicaid Program," Georgetown University Health Policy Institute Center for Children and Families (December 2007), available at http://ccf.georgetown.edu.

[13] The Medicaid Transformation Grants were enacted in the Deficit Reduction Act of 2005 to improve the effectiveness and efficiency of the Medicaid program. States can use them to reduce patient error rates through information technology, implement medication risk management programs, improve access to care, reduce spending on prescription drugs in "clinically appropriate ways," increase rates of estate collection, and improve program integrity. For information see http://www.cms.hhs.gov/MedicaidTransGrants/01_Overview.asp#TopOfPage

[14] Executive Order, *Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs*, August 22, 2006, available at http://www.whitehouse.gov/news/releases/2006/08/print/20060822-2.html and Value Driven Health Care, http://www.hhs.gov/transparency/.

[15] op. cit. (11).

[16] Centers for Medicare and Medicaid Services, "Overview, Better Quality Information to Improve Care for Medicare Beneficiaries Project," available at http://www.cms.hhs.gov/BQI/ (September 11, 2008) and Letter on Value-Driven Health Care (VHC)/Medicaid Quality Improvement Program (MQIP) from Dennis Smith, Director, Center on Medicaid and State Operations, to State Medicaid Directors, April 25, 2007, SMD #07-005, Enclosure B.

[17] Government Accountability Office, "Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars is Limited," GAO-05-855T (June 28, 2005); Government Accountability Office, "Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse," GAO-06-578T (March 28, 2006); and V. Wachino, "The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid," Kaiser Commission on Medicaid and the Uninsured (June 2007), available at http://www.kff.org.

[18] For more information on CMS' Medicaid Integrity Program, see http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp#TopOfPage.

[19] See presentation by J. G. Shaheen, "The Future of Medicaid Regulation: Compliance Issues in Medicaid," New York Medicaid Inspector General (June 6, 2008).

[20] Government Accountability Office, "Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments," June 2004.

[21] V. Smith, et al., "State E-Health Activities in 2007: Findings from a State Survey," The Commonwealth Fund (February 2008), available at http://www.commonwealthfund.org.

[22] Centers for Medicare and Medicaid Services, "Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, FYs 2008-2012" (June 2008), available at http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp#TopOfPage.

[23] For more information on state false claims acts, see Taxpayers Against Fraud web site, http://www.taf.org/statefca.htm.

[24] 42 *CFR* 433.316-322.

[25] Statement of Raymond Sheppach, Executive Director, National Governors' Association, before the Medicaid Commission, August 17, 2005.

About this Project

This paper is part of "Strengthening Medicaid," a project initiated in 2007 by the Center for Children and Families (CCF) at the Georgetown University Health Policy Institute, working with health policy consultant Victoria Wachino. The program develops fresh ideas to strengthen the Medicaid program and to engage policymakers and stakeholders at the state and federal levels in discussion about how these ideas might be translated into policies. These approaches focus on (1) promoting access to high-quality, cost effective care that meets beneficiaries' needs; (2) improving coverage options; and (3) assuring sustainable financing while ensuring that available resources are used in the most efficient way. These approaches, which are presented through a series of short policy papers, represent some of the best ideas from a number of experts in different areas, including some who bring their expertise from outside of Medicaid to the Medicaid context. The policy papers are edited by Joan Alker, Deputy Executive Director of CCF and consultant Victoria Wachino.

For more information visit the project's web site at http://ccf.georgetown.edu/index/strengthening-medicaid.

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